

Friday, 8 May 2026

1
2 (1.45 pm)
3 **THE CHAIR:** Yes, Mr Ivory.
4 **MR IVORY:** Good afternoon, Chair. May I please call
5 Mr David Waldron?
6 **DAVID WALDRON (sworn)**
7 **Questioned by MR IVORY**
8 **THE CHAIR:** Yes, Mr Ivory.
9 **MR IVORY:** Mr Waldron, you've provided the Inquiry with
10 a statement dated 2 February 2026. Can you confirm that
11 its contents are true to the best of your belief and
12 knowledge.
13 **A.** Yes, I can.
14 **Q.** Your role at Nottinghamshire Healthcare NHS Foundation
15 Trust is the Out of Area and Subcontracted Clinical Lead
16 for Bed Management. Can you just tell us what that role
17 involves?
18 **A.** Okay, so my role now, as previous to when I first gave
19 the original statement, is the Subcontracted Lead is
20 there to provide oversight of individuals that are going
21 into our subcontracted beds or spot purchase beds when
22 a local bed is not available.
23 I work alongside senior members of the team now to
24 provide the -- not only the oversight of getting
25 an admission arranged or a discharge arranged, but also

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1 **Q.** In terms of your role and the role of your team, the Bed
2 Management Team, to what extent is that a clinical role?
3 What discretion or judgement do you have when choosing
4 what type of bed a patient goes to, what type of service
5 they're referred to?
6 **A.** Okay, that refers to the gatekeeping elements, which
7 I believe you've heard of before, from the Crisis Teams
8 who have to oversight all arrangements for when a bed is
9 required, and the nature of that bed. So just to be
10 clear to everybody, there is what we would call an acute
11 bed for an individual or, if that individual required
12 it, a PICU or Psychiatric Intensive Care Unit bed.
13 And once that gatekeeping has been done, it becomes
14 the role of the Bed Management Team to be looking for
15 those beds as soon as possible, so that the individual
16 can be placed safely into those hospitals.
17 **Q.** Would you have any involvement in the decision as to
18 whether a particular patient goes to an acute bed or
19 a PICU bed?
20 **A.** Yes. We would. In terms of the clinical aspect, just
21 to explain that it's a nursing team, and the information
22 that is given, such as risk assessments,
23 Multi-Disciplinary Team reviews and feedback from the
24 community to ourselves, that does enable us to look at
25 the certain elements such as risk elements, the need of

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1 to ensure that we're in contact with the service user or
2 patient in this case, and the clinical teams, wherever
3 that might be.
4 **Q.** And in your role title, there's two references there,
5 one to out of area beds and one to subcontracted beds.
6 **A.** Mm-hm, yes.
7 **Q.** Can you tell us about the difference between those two?
8 **A.** Yes, the difference is the subcontracted bed, it's in
9 one particular hospital where the subcontract is
10 arranged by my seniors and that is there to ensure that
11 we've got local, although we say out of area, we're
12 talking about local beds nearby hospital to the Trust
13 when we don't have any local beds available.
14 The spot purchase bed is more of a non-contracted --
15 it's a different contract, as opposed to a subcontract,
16 in terms of it's a spot purchase arrangement which is
17 for individuals when we haven't got enough local beds
18 available and we place individuals in the subcontract --
19 in the spot purchase beds.
20 **Q.** So the difference then, on the subcontracted side that's
21 a regular arrangement in the local area?
22 **A.** Mm-hm.
23 **Q.** Whereas spot purchase beds are, people are admitted to
24 them on an *ad hoc* basis; is that the distinction?
25 **A.** Yes.

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1 the individuals themselves. One proviso that I want to
2 be clear on is that sometimes it isn't appropriate for
3 an individual go into a local bed. For example, there
4 may be a staff member known to the Trust, or there may
5 be safeguarding issues and reasons to place individuals
6 in what we call an out-of-area bed.
7 **Q.** Does the exercise of that judgement as to what type of
8 bed or service the patient goes to, extend to referral
9 to forensic services, for example.
10 **A.** It can do, but I would say usually we are -- in the
11 adult mental health Bed Management Team, we do have
12 individuals that might be oversights by the community
13 forensic teams, but if those things come up, they are
14 discussed at the time with the clinicians where the
15 individual is.
16 So if a forensic referral is required, we can look
17 at that and feed that back to our own community teams.
18 It's very much about communication with the wide -- when
19 I say MDT, Multi-Disciplinary Team, we do look at the
20 adult mental health side of things but also the forensic
21 side of things as well.
22 **Q.** When a patient does go to subcontracted bed or spot
23 purchase bed, what's the role of the care coordinator
24 within that?
25 **A.** So that's outlined in the Continuity of Care Principles.

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1 So just to explain to everybody that we are looking at
2 if a care coordinator is in place for that individual at
3 the time of admission, there is an expectation that
4 there is no difference between them seeing them maybe on
5 a weekly basis as they would in the community locally,
6 if that was the case and was the case in this situation,
7 that the CCO would be regularly in touch, with that
8 service user and their family.

9 **Q.** When we come to VC we know he went first to Cygnet
10 Victoria House and then the Priory Arnold. Were those
11 spot purchase beds or subcontracted beds?

12 **A.** They were -- the first one you've described, Victoria
13 House, was spot purchase because there was a requirement
14 for PICU, again, Psychiatric Intensive Care Unit. And
15 then on the step down at the time that we are
16 discussing, there was a subcontracted element at
17 Bestwood Ward or Priory Arnold, at that time.

18 **Q.** Does the information-sharing arrangement differ
19 according to whether it's a subcontracted service or
20 a spot purchase service?

21 **A.** No, I wouldn't indicate that here.

22 **Q.** What about in terms of access to RiO?

23 **A.** So there are obviously confidentiality elements to all
24 uses, whether it be RiO or care notes or whatever that
25 might be. But that being said, it's very important to

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1 still confidential for that care team, for the service
2 user themselves, and any family members that that might
3 be. So I hope I've explained that one.

4 **Q.** We've heard evidence from some of the clinicians at
5 Cygnet, at Victoria House, about how they didn't have
6 access to the RiO progress notes.

7 **A.** Right.

8 **Q.** Do you know why that would have been?

9 **A.** I wouldn't know why that would be, to be honest, because
10 that is part of the original, when the gatekeeping is
11 there, is done, that would be a part of the bed
12 management role to ensure that there is oversight of
13 those progress notes. So I'm not sure why that would be
14 the case.

15 **Q.** What if a hospital, in their own systems, they don't use
16 RiO, they use a different electronic patient record
17 system, how does access to RiO work then?

18 **A.** So again, it's about information sharing. So it's the
19 case of if you've got, you know, as I say I've just
20 explained about there's RiO, there's care notes, there's
21 all sorts of other patient systems, but it is a case of
22 ensuring that we are sharing those informations. We
23 look at that in terms of, as I said, about risk
24 assessments but if there were particular clinical alerts
25 and things like that we are duty bound to make sure that

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1 understand that we do share information so that the spot
2 purchase or subcontracted team can have full access and
3 knowledge of the information required. And that's
4 important so that they, just to go back to the original
5 gatekeeping, that we would indicate the provision of
6 individual clinical notes, so that might be risk
7 assessment, it could be the MDTs leading up to the
8 admission, and core assessments which would be about the
9 person's physical needs, psychiatric needs, and plans
10 which were in the place in the community going forward,
11 so that that isn't lost for the individual as they go
12 through the inpatient side of their care.

13 **Q.** In terms of RiO access, you mention there
14 confidentiality comes into it.

15 **A.** Mm-hm.

16 **Q.** Why does confidentiality come into it when necessarily
17 a patient is at a particular provider, they're under
18 their care, they need access, presumably, to the
19 records. Why is confidentiality a factor?

20 **A.** Well, it's just to ensure that everybody is aware that
21 the sharing of information is appropriate and
22 I haven't -- hopefully I haven't misled you on that one,
23 that there is the sharing of information, and therefore
24 it's just to ensure that the information goes to that
25 particular provider with the knowledge that that is

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1 information goes forward, and also with the CCO or CPN
2 in place that could be further discussed at the weekly
3 meetings or MDT reviews.

4 **Q.** As a matter of practicality, some hospitals, some
5 Trusts, don't use RiO.

6 **A.** Mm-hm.

7 **Q.** Your trust does.

8 **A.** Mm-hm.

9 **Q.** If you're trying to provide access to RiO notes how does
10 that work, if they don't use that system?

11 **A.** Right, okay. Well, again it's about information
12 sharing. So if there are -- that would be identified by
13 the particular provider saying, "Can we have any
14 information on these things?" And because it's from
15 a Trust-to-Trust case of information sharing, if that --
16 that can be done. It's not --

17 **Q.** How can it be done?

18 **A.** Through confidential emailing and things. You know, we
19 can share information, password protected, et cetera, so
20 that we don't breach our own IT -- (*overspeaking*) --

21 **Q.** So would that be a matter of emailing a pdf file of the
22 existing notes?

23 **A.** Yes, it can be, yeah, it can be. But we are very
24 careful about this and I hope I'm not misleading on this
25 because it is important that the provider does receive

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1 the information that they require. But also, there is
 2 obviously verbal handover and, as I say, with the CCO in
 3 place, they can provide further information, for the
 4 teams.

5 **Q.** And who takes responsibility for making sure that the
 6 provider a patient has gone to has access to the
 7 material they need?

8 **A.** That would be the CCO in place and also, particularly on
 9 admission, or on discharge, the Bed Management Team
 10 would be involved in that. One point to make now is the
 11 changes that have occurred since I was a bed coordinator
 12 then moved into this role is we have ensured that we are
 13 more present within bed management meetings and also the
 14 reviews themselves, and that is a significant change in
 15 last few years.

16 **Q.** When access is provided to the RiO system, I understand
 17 it's on a read-only basis, so they can't make edits,
 18 they can't make new notes on the system.

19 **A.** Mm-hm.

20 **Q.** Do you ever have reported to you issues about that
 21 problems that causes, administrative difficulties?

22 **A.** Personally I haven't, no. In terms of feedback from
 23 individual providers, there hasn't been an issue with
 24 that and, as I say, it's a two-way situation. So we
 25 want to make sure we've got, you know, the up-to-date

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1 the evidence and information that we require to pass on
 2 to teams.

3 **Q.** We'll move on to VC. The documentation you receive at
 4 the outset is, you say, a PICU gateway referral form and
 5 it is a Crisis Team gatekeeping form; is that right?

6 **A.** Yes.

7 **Q.** If we could have up on screen NHFT0017964, please, and
 8 we'll start with page 1. This is gatekeeping
 9 documentation compiled by the Crisis Team. I think you
 10 say, it explains the rationale for detention and
 11 admission. Is it right that this is very much
 12 a compilation, it's information composed of or from
 13 various sources within this document?

14 **A.** Yes, that's right. So it begins with the demographics.
 15 As you can see, it goes on to CPA information, so
 16 that's -- the Care Programme Approach information is
 17 there. So known information historically is available,
 18 kind of thing, although I would point out that because,
 19 although the Crisis Team do place this in, if the
 20 individual is known, which is the case with VC,
 21 previously, that would be available to the Bed
 22 Management Team previously as well, in terms of --

23 **Q.** You'd have the RiO records?

24 **A.** -- the documents. We'd have the RiO records, yeah.

25 **Q.** If we could have page 10 of this document on the screen,

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1 notes. There's an expectation, contractually arranged,
 2 that we have access to the updates that are being made
 3 for the individual by that particular provider, at any
 4 point in time.

5 **Q.** Would you have direct access to their patient record
 6 system in order to do that?

7 **A.** No, no --

8 **Q.** You'd be relying on stuff being emailed over,
 9 essentially?

10 **A.** Yes, yes, that's correct. But also as a sight in this
 11 case that the CCO was in place and would be able to make
 12 their own notes and feed that back to our team and other
 13 members of our Trust.

14 **Q.** It sounds like it's very much a manual process, which is
 15 dependent on individuals in your Trust and in the other
 16 provider, finding each thing which is relevant, making
 17 sure they attach it to an email and sending it over; is
 18 that fair?

19 **A.** Yeah, I believe that's a fair comment but I don't --
 20 I just need to be very clear that information sharing is
 21 a principle part of the -- you know, the role that we do
 22 within the Bed Management Team. That's why we brought
 23 in senior members. We now have senior flow managers and
 24 oversight is of a higher grade, so that they can ensure
 25 their experience is used to make sure that we do get all

10

1 please. In that bottom box, it appears essentially at
 2 the bottom box, an extract -- a copy and paste lifted
 3 from the Mental Health Act Assessment by Dr Lomas of VC.
 4 If we go on to the next page, the two large paragraphs,
 5 we see the description -- in fact the 3 paragraphs
 6 there -- the description of what happened when they
 7 attempted to assess VC. You'll no doubt be familiar
 8 with this account of VC assaulting the officers during
 9 the attempted assessment and the attempt to bring VC to
 10 a place of safety.

11 That's set out as that entry in this compiled
 12 document. If we turn to page 7, please, we have
 13 a different entry included in this document by a nurse
 14 and if you see under the heading "Presenting problem",
 15 about halfway down on the screen currently, it gives
 16 a different account about VC trying to barge into
 17 a neighbour's flat and then police being involved. It
 18 goes on to say:

19 "Historically when unwell he has forced entry into
 20 his neighbours' houses under the influence of his
 21 psychotic experiences, though no violence has resulted."

22 It seems to elide the incidents which have happened,
 23 the Brook Court incidents in 2020, where VC tried to
 24 break into flats, and the incident that has just
 25 happened, where he's assaulted police officers; do you

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1 see that, where this entry has gone wrong?
 2 **A.** Do I see that, in terms of ...?
 3 **Q.** Have you heard the evidence about the Brook Court
 4 incidents, are you aware of those?
 5 **A.** Yes, I have, in the preparation for this Inquiry.
 6 **Q.** Those happened in summer 2020.
 7 **A.** Mm-hm.
 8 **Q.** Now this entry is the 4 September 2021. So it's a day
 9 after the assault on PC Pritchard, a different incident
 10 which occurred when a Mental Health Act Assessment was
 11 attempted. This doesn't seem to make mention of that
 12 assault. It's then said talking about eliding incidents
 13 in respect of Brook Court; do you see that?
 14 **A.** Mm-hm.
 15 **Q.** Then what seems to happen, if we turn to NHFT0018311,
 16 that's first referral to Cygnet, isn't it? "Referral
 17 Form" on 4 September.
 18 **A.** It is, yeah.
 19 **Q.** And it's a form completed by you, do you see on the top
 20 right?
 21 **A.** Mm-hm.
 22 **Q.** And if we turn to page 3, that bottom box, "Additional
 23 information":
 24 "Prior to Detainment
 25 "[VC] had gone to neighbour's flat who was staying
 13

1 that falls into error when you're completing this
 2 referral form?
 3 **A.** Yeah, I could see that, to be fair.
 4 **Q.** When referral information comes to you and then you're
 5 passing it onwards to another provider, would you fact
 6 check it at all or check it for accuracy?
 7 **A.** Yes, I would do, in that case.
 8 **Q.** How would you do that?
 9 **A.** With the referring documents that we receive, and see
 10 what's on RiO so that we can forward that on.
 11 **Q.** And of course --
 12 **A.** I do see your point.
 13 **Q.** Yeah. So what do you think has gone wrong here?
 14 **A.** Yeah -- yeah, as I say, I don't really have a response
 15 to that one at the current time. I can see the point
 16 that you're making. I'm sure, at the time, that was --
 17 that is information was provided with the best evidence
 18 that we had but I can see the point that you're making.
 19 **Q.** Because if you had looked at some of the other RiO notes
 20 here it would have been quite obvious what different
 21 incidents had occurred and the violence which had taken
 22 place in each of them, wouldn't it?
 23 **A.** It would.
 24 **Q.** If we finally have that up, if we have on screen
 25 NHFT0000168 and it's page 196. It doesn't have the date
 15

1 above him, knocked at his door to confront him as to why
 2 he was discussing him as he had heard voices to that
 3 effect and he was certain that it was this person living
 4 above his flat responsible. He barged into the persons
 5 flat and wanted the person to admit what he was doing,
 6 and other neighbours came to the rescue and called the
 7 police."
 8 Then over the page:
 9 "[VC] is known to [the] services ..."
 10 And it says:
 11 "Historically when unwell he has force entry into
 12 his neighbours houses under the influence of his
 13 psychotic experiences, though no violence has resulted."
 14 You've lifted that from the earlier entry on that
 15 form, haven't you? It's word for word the same, so
 16 presumably you've copied and pasted it from the
 17 information you've been provided; is that right?
 18 **A.** Yeah.
 19 **Q.** Is that right?
 20 **A.** Yes.
 21 **Q.** But there's no mention in that additional information
 22 about what happened prior to detainment in terms of the
 23 attempted Mental Health Act Assessment and the
 24 description of the assault of the police, and it talks
 25 about no violence having been resulted. Do you see how
 14

1 at the top but it's 3 November 2021, and it's an entry
 2 by you, but to be fair to you I think here you're just
 3 entering in the information which is on the Discharge
 4 Summary from the Priory, so this is at the end of those
 5 admissions. Is that what you'd be doing in this entry?
 6 You'd just be copying across the discharge information?
 7 **A.** We will want to provide the information that we have
 8 available to us. I'm a little bit bemused by the
 9 question there because, as I say, what we are trying to
 10 capture is the risk information in this situation.
 11 So -- and I can acknowledge your point.
 12 **Q.** Yes, but just to be clear, if we could zoom out again
 13 just towards the top, we've got OOA coordinator entry
 14 and it goes on to give details of the discharge from the
 15 Priory.
 16 **A.** Mm-hm.
 17 **Q.** I just want -- in all fairness to you, we've got a date
 18 of discharge as well on this document. It appears you
 19 were just entering in the Discharge Summary into the RiO
 20 record. Is that what you understood this to be or do
 21 you understand it to be some --
 22 **A.** Yes, and we would want the Discharge Summary to be in --
 23 **Q.** Yes.
 24 **A.** -- in the records.
 25 **Q.** But if we go down to -- further down the page to
 16

1 "Rationale for admission", including summary of
 2 presentation, we again see what looks to be this eliding
 3 of the sets of incidents because it talks about the
 4 admission being preceded by an episode of psychosis,
 5 where he barges into his neighbour's apartment and then
 6 he assaults police officers when they confront him. So
 7 tell me if you agree or disagree here: what looks what
 8 like happens is that we have that erroneous ended
 9 included in that Crisis Team referral form. You include
 10 it in your own referral form to Cygnet, and when we come
 11 all the way to discharge from the Priory, that erroneous
 12 information is still carried through in the entry?

13 **A.** So yes, I can acknowledge, yeah, the point that you're
 14 making.

15 **Q.** That's of course going to be confusing, potentially
 16 misleading, to anyone down the line who comes to look at
 17 this entry to see why VC was admitted in September and
 18 October?

19 **A.** (*The witness nodded*). Mm.

20 **Q.** Is that right?

21 **A.** Yes, I do acknowledge your point.

22 **Q.** More generally -- and that can come down now -- during
 23 a patient's admission at a third-party provider, whether
 24 it's a subcontracted or a spot purchase bed, you receive
 25 various records from them during the course of that

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1 we have, which we would call local wards, moving on to
 2 the subcontracted or spot purchase wards. That begins
 3 at Priory Nottingham and works downwards, and it shows
 4 the number of individuals, male or female, that we have
 5 on those wards at the time, and it also includes the 136
 6 suites, Jasmine and Cassidy, just to indicate again the
 7 amount of individuals that are in place at that time.
 8 So it shows the number of service users as inpatients.

9 **Q.** This on 4 September 2021.

10 **A.** Yes.

11 **Q.** When we're looking at this, what impression should we
 12 draw from this in terms of bed availability? Is it
 13 a good picture; a bad picture?

14 **A.** It shows the high acuity that was around at the current
 15 time. We've got to put this in the context of Covid as
 16 well, I just want to make that point, because that also
 17 did have relevance to bed availability, given if there
 18 were outbreaks on individual wards, because we don't
 19 want to put individuals at risk, you know, at the time.
 20 But, putting that aside, it does show that there is
 21 availability on -- whether it be on the male side or
 22 female side but it also indicates that there isn't
 23 availability as well at the time for VC.

24 **Q.** That can come down now, please. At this time on
 25 4 September, VC is in a temporary section 13 bed in the

19

1 stay, don't you?

2 **A.** Mm-hm.

3 **Q.** What sort of auditing or accuracy checking would you be
 4 making of those records to see whether they're completed
 5 correctly, whether the information looks right, would
 6 you carry out?

7 **A.** Okay, so in terms of the clinical audit, that is a part
 8 of the bed management role and we do have -- as I say
 9 I'm not working alone, we do have individuals
 10 overlooking (*sic*) our notes and there is a quality
 11 aspect to the oversight of notes that are coming in
 12 within the team. That is built into our system.

13 **Q.** How would they carry out those audits?

14 **A.** Audits are -- from what I'm aware of, it's a different
 15 part of the team but those audits are conducted on --
 16 I'm not sure on the timeframe but they are conducted by
 17 these -- what we call the performance management part of
 18 the Trust.

19 **Q.** If we go back to the beginning of VC's admission and the
 20 bed situation then, if we could have on the screen
 21 WITN0389003, please. Could you just tell us what we're
 22 looking at here?

23 **A.** Okay. So this would be -- at the time that this was
 24 done, this shows the bed management current situation
 25 relating to individual wards on the left-hand side that

18

1 Cassidy Suite, isn't he?

2 **A.** He is. Yes.

3 **Q.** That bed was stepped up, and that allows him to be
 4 treated there in seclusion until you find an appropriate
 5 bed; is that right?

6 **A.** It is, yeah, and just to explain, the step-up process
 7 does basically mean that the bed goes from a 136 Suite
 8 to an enacting of the Mental Health Act Assessment,
 9 which was a Section 2.

10 So that bed should be seen as a local bed like
 11 another acute bed would be, around the local area, kind
 12 of thing. But during this time, the subcontext to that
 13 is the fact that during the Mental Health Act Assessment
 14 it was felt that we needed to find an intensive care
 15 bed, given the presentation of VC at the time.

16 **Q.** The inevitable consequence of that is you lose
 17 a Section 136 bed, don't you?

18 **A.** That's correct, yeah.

19 **Q.** In terms of the Trust's general availability, losing
 20 a Section 136 bed, how significant is that? How many
 21 such beds available?

22 **A.** Yeah, that is a good point, because ultimately it does
 23 impact on flow, kind of thing and that's why --

24 **Q.** How many beds does the Trust have available to it as
 25 places of safety?

20

1 A. Places of safety is four, yeah.
 2 Q. So you're losing a quarter?
 3 A. So you're losing a quarter, yeah, during that time. And
 4 that's why the Bed Management Team, as I've hoped to
 5 have evidenced in my evidence, the rationale for
 6 constant meetings and discussions about the move-on
 7 options as indicated in my evidence.
 8 Q. What happens if you don't have enough places of safety
 9 left to meet the demand from AMHPs or for a Mental
 10 Health Act Assessment to take place?
 11 A. Well, I can recognise that that can have knock-on
 12 effects but clinically-wise, the situation is this is
 13 why we have the escalating -- (*overspeaking*) --
 14 Q. But what actually, as a matter of practicalities,
 15 happens in those circumstances? What does the Trust do?
 16 A. Well, that's when those discussions about out-of-area
 17 beds, spot purchase beds, et cetera, are convened as
 18 soon as they possibly can be. I mean, the aim is always
 19 to have an individual in the local bed just so we can
 20 provide the care we would wish to do. But that being
 21 said, as you've indicated, due to acuity that isn't
 22 always possible. That's the rationale taken.
 23 Q. We know that VC gets transferred to Cygnet in
 24 13 September, so he's in the Cassidy Suite for ten days.
 25 Is that typical for --

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1 that they're, you know, at the PICU provides specific
 2 support to individuals including, you know, having
 3 enough, you know, staff availability as well as
 4 specifically trained staff, I would say.
 5 In this case there was, once he was stepped up,
 6 there was more -- there were more staff made available
 7 for that, but I do recognise your point.
 8 Q. We know that referrals are made to various providers,
 9 and they're declined. If we could have on screen
 10 NHFT0000168 and it's page 178.
 11 It'll be the top box there. For reference that's
 12 dated 6 September 2021. What we can see is a referral
 13 being declined and the reason given being:
 14 "... the risks presented by [VC] ..."
 15 And the need for seclusion, and it's suggested that:
 16 "... a placement with a predominantly male team or
 17 secure services may be more appropriate."
 18 Did you at this point consider whether VC should be
 19 referred to secure services or at least be assessed for
 20 secure services?
 21 A. Again, this would come down to the wider MDT and the
 22 escalations that we were making. In terms of the secure
 23 service, my understanding is that we did go on to make
 24 those referrals, but at the time, I can see the point
 25 that you're making.

23

1 A. No.
 2 Q. -- a stepped-up bed?
 3 A. No, that wouldn't be typical. Again, I'd put the case
 4 forward about the Covid scenario because you will see in
 5 my evidence the number of attempts made to find
 6 a private provider or a spot purchase provider.
 7 There's, you know, that is indicated by -- because we're
 8 a 24/7 working team and you will see the amount of times
 9 we looked to support VC with a move -- (*overspeaking*) --
 10 Q. Mr Waldron, I appreciate you want to give fulsome
 11 answers to the questions I'm putting to you and your
 12 reasoning behind them, but we've got limited time so if
 13 you could just stick to answering questions I've asked.
 14 A. I apologise.
 15 Q. In terms of the suitability of the place of safety bed,
 16 once it's stepped up, does that provide the same sort of
 17 care a PICU would?
 18 A. I have to say no, in that respect. What I would say is
 19 that there are, you know, the staff there, we have to
 20 look at this across the board. If there are those
 21 concerns, we would step up staff -- (*overspeaking*) --
 22 ability.
 23 Q. In what sense does it not provide the same --
 24 A. Well, for example, the use of seclusion, it can be used,
 25 it is allowable kind of thing. But in terms of ensuring

22

1 One thing to note with the sectioning kind of thing,
 2 it was felt by all the attendees at the MDT that
 3 a Section 2 would be appropriate. There wasn't, to my
 4 knowledge -- and it doesn't mean I'm right -- but to my
 5 knowledge at the time I don't perceive there was a call
 6 for secure step-up referral to be made, and I have to be
 7 honest about that.
 8 Q. Is that your recollection of the MDT?
 9 A. That is my recollection at the time.
 10 Q. Was it discussed at the MDT?
 11 A. As I say, I'm not -- you've got to put this into
 12 24 hours a day, seven days a week. I might not have
 13 always been present, I could have been
 14 -- (*overspeaking*) --
 15 Q. Have you seen a record of it being discussed at the MDT?
 16 A. Not to my knowledge I haven't, but I think -- well,
 17 I know that it did happen further down the line. But
 18 not at the time of the point you're making.
 19 Q. I think you suggested there that referrals were made to
 20 secure services; is that what you said?
 21 A. Not at the time. I see the point you're making there
 22 but --
 23 Q. But when?
 24 A. -- further down the line. Once the assessment
 25 continued, when VC was moved and did have an intensive

24

1 care bed.

2 **Q.** So you're saying after he arrived at Cygnet?

3 **A.** It would have been the case because, as I say, the main

4 point of the Bed Management Team is to put these things

5 in place, and as part of the referral.

6 Within my knowledge of the gatekeeping referral,

7 that wasn't indicated to the team at the time that I'm

8 aware of but, as I say, we've got to put this in the

9 context of the need to find an appropriate bed for the

10 individual.

11 **Q.** You say it wasn't indicated, but in this email from

12 Cygnet Victoria House it has been indicated, hasn't

13 it? It's saying:

14 "[The] ... recommendation that a placement with

15 a predominantly male team or secure services may be more

16 appropriate."

17 **A.** Right, yeah. That's the -- yeah, I can see what you

18 mean. That's the recommendation by the team themselves,

19 but again my understanding would be that we would take

20 this -- yes, I see what you mean, sorry. Myself or my

21 colleagues at the time would look to pass that

22 information on.

23 **Q.** And in fact --

24 **A.** And it would be within the RiO system for all to see.

25 **Q.** In fact what we see happens, if we go to the next page,

25

1 a predominantly female nursing team. Are you saying

2 they might have replaced their nursing team with a male

3 team?

4 **A.** No, I'm not saying that, but they could bring in male

5 individuals, for example, to do the support on the wards

6 themselves. There's the whole STN or observational side

7 of nursing within acute and PICU environments, where

8 staff numbers can be increased to meet the needs of

9 individuals themselves, and I think that's a reasonable

10 point to make here.

11 **Q.** That can come down now. If we can have on the screen,

12 please, NHFT0018341.

13 This is Patient Review documentation from Cygnet, so

14 once VC is at Cygnet Victoria House. And you say in

15 your witness statement this was sent to you on

16 21 September. So this is part of the records from

17 Cygnet that you got sent to your team; is that right?

18 **A.** Yes, it would be an update, or it could have been

19 entered by the CCO herself.

20 **Q.** If we just scroll through this, pages 1, 2 and 3, it

21 looks like parts of it haven't been filled in. If we go

22 to the next page, "Patient Feedback" section, for

23 example, there's nothing there. Did you pick that up at

24 the time?

25 **A.** I can't honestly say that I did pick that up at the

27

1 sorry, not the next page, NHFT0000168 page 188, page 188

2 on the 9 September. Back one page, please. Thank you.

3 NHFT0000168 page 187. That entry at 4.33 pm:

4 "referrals resent into Cygnet for reconsideration.

5 "p[atien]t no longer in seclusion ..."

6 We know that referral is eventually accepted. Is it

7 fair to say that it was VC's downgrade from seclusion

8 which allowed him to get a bed at Cygnet Victoria House?

9 **A.** That's a possibility, but I've got to be very clear that

10 in this term, one, there could be that there is a change

11 in a settling in mood and mental state, but I would also

12 put forward the point that all of these providers can

13 have access to the provision of appropriate staff

14 members, so they would look at their referrals, and that

15 is in my knowledge that all the parties that we do work

16 with do actually and can actually make available, you

17 know, previously they discussed about having an

18 all-female team at that time. That can change. This is

19 a flexible situation that we're looking at.

20 So in terms of yes, there could be the point that

21 you're making about the improvement in mood and mental

22 state but I also think it's important to indicate to

23 everybody here that there is a flexible, changeable

24 situation, in terms of staff teams on the providers.

25 **Q.** Well, three days ago, the issue was that they had

26

1 time, or my colleagues that were working at the time

2 that this was passed on to us. I have to be completely

3 honest about that.

4 **Q.** If you're keeping an eye on the providers you're sending

5 patients to, do you think you should have?

6 **A.** Well, again, at the time that these points were being

7 made and this information was coming back to us, the

8 actual oversight with the continuity of care policy that

9 we had, it should be the CPN ultimately responsible.

10 We've made many changes since then which I've indicated

11 again in my evidence to ensure things like this

12 shouldn't happen but at the time I have to acknowledge

13 that that was more an assessment that should have been

14 conducted by the CPN themselves.

15 **Q.** If we go to page 5 of this document, we see some action

16 points. We've got a tribunal hearing in two days' time:

17 "Section 3 should be considered after that

18 "Depot antipsychotic medication should be considered

19 if detained on section 3".

20 Reading that, the picture one gets is that this is

21 someone who is still unwell, quite unwell because

22 they're considering continued detention under Section 3.

23 Is that the impression you get?

24 **A.** I can understand the point you're making, yes.

25 **Q.** So that is the impression you get from reading this?

28

1 A. It is.

2 Q. If we have next on screen, please, WITN0389008. So that
3 document we just saw was sent to you on 21 September.
4 Someone, a nurse from Cygnet, has emailed you on the
5 23rd stating:
6 "... [VC] is ready to be stepped down [on] to an
7 Acute bed, he is currently detained on section 2 ..."
8 Now this in fact on the 23rd, the same day that the
9 Mental Health Tribunal had determined VC was still
10 liable for detention, and it's in fact before the
11 application for transfer to Section 3 is made.
12 Does it strike you as premature, at all, talking of
13 stepping down to an acute bed?
14 A. We have to go on the clinical information provided by
15 the PICU team at Victoria House. So that's not
16 something that I can easily answer, because my
17 understanding of it is that there was interaction
18 between the CPN and the team themselves. So that is
19 a difficult one for me to respond to.
20 Q. Would it be preferable, we're talk about stepping down
21 to an acute bed here, for VC to stay at Cygnet for
22 continuity of care purposes? Would that be a factor
23 that comes into consideration here?
24 A. Well, as I say, the evidence that I've passed on further
25 to this is that we would always want, in the best

29

1 A. Well, as I say, we've got to be very clear that whilst
2 the Bed Management Team has changed, you know, and
3 evolved in many ways, at the time that would sit with --
4 you're asking me questions that really should be going
5 to the CCO because they would be the ones that would
6 ultimately, as indicated by the continuity of care
7 principal document, is that they would look at providing
8 all referrals as indicated by the clinical team or
9 requested by the clinical team. So that is a tricky one
10 for me to answer when looking at it at the time.
11 Q. But if a secure bed was sought, would it not be your
12 team who seeks that?
13 A. There wasn't any requests for a secure bed. I've got to
14 be clear there wasn't --
15 Q. There wasn't any requests for a secure bed?
16 A. Not that I'm aware of, no. There was a --
17 Q. So in your evidence earlier, where you said referrals to
18 secure services were made at some point during this
19 period, what was that based upon?
20 A. That was based upon my knowledge of the evidence given
21 to the CPN that was involved and not ourselves.
22 Q. Right. One thing you say in this email is step-downs do
23 remain a priority. Why is that?
24 A. Sorry, why does step-downs remain a priority?
25 Q. Yes.

31

1 interests of that individual, to get them back to
2 a local bed where continuity of care could continue and
3 I've indicated that in a number of documents beyond this
4 particular page. But it is an important point you make
5 and I do recognise that. We do work with that team
6 still and we do still look at step-down if that is to be
7 appropriate.
8 Q. If we look at your reply to that, at the top it says:
9 "Things remain tight for male beds but I'm
10 escalating to seniors this morning."
11 If we have next on screen WITN0389009, a chaser has
12 been sent on the 28th from Kirsty Wilson at Cygnet and
13 you reply:
14 "We're working on repatriating VC but unfortunately
15 we don't have any male bed availability at the moment.
16 We assess the situation each day and he's on the list
17 for return to an acute bed and step-downs do remain
18 a priority."
19 So on the 23rd, the request for this step-down has
20 been made into an acute bed and you're here saying he's
21 on the list for return to an acute bed. You said
22 earlier that at some point during his admission he was
23 under consideration for referral to secure, and those
24 referrals were made. Was it around this time those
25 referrals were made to secure services?

30

1 A. Because we're trying to get the individual, once
2 they're -- that portion of their care is secured, we are
3 trying to support individuals to step down. That's
4 a genuine clinical indication to the team of our efforts
5 being made.
6 Q. If we could have next on the screen WITN0389010. And
7 it's another chaser email from John Laverick, a senior
8 nurse at Cygnet, chasing to see if any progress has been
9 made to getting a bed and you say:
10 "Thanks John, that's my bad, I ought to discuss
11 something with the team to see if I can get something
12 going. Have a nice evening."
13 Then if we turn and have next on screen, please,
14 WITN0389011. You forward this to your own team asking
15 if you:
16 "... could look at sending this to Bestwood ... the
17 cygnet team are getting a little bolshy ..."
18 Did you feel under pressure at this point to obtain
19 a bed for VC?
20 A. I feel that the Bed Management Team is always under
21 pressure to provide the right and adequate bed. I have
22 to acknowledge my language used there at that point is
23 not particularly professional and apologise to that.
24 But, that being stated, the context of the actual
25 individual that I name at Bestwood it's one of the ward

32

1 managers. So all the time that this has been going on,
 2 we have been escalating, we have been requesting not
 3 only for the local bed, because I have indicated in my
 4 evidence that that was turned down a number of times by
 5 senior management in their respect of trying to get
 6 a local bed for VC. Ultimately, we were taking action
 7 to secure a bed as soon as we could.

8 **Q.** Why Bestwood?

9 **A.** That was one of the subcontracted beds at the time. So
 10 Bestwood is part of Priory Arnold which was, again,
 11 a local bed in terms of distance, you know, to
 12 Nottingham. It's within the Nottingham area.

13 **Q.** You've named it in particular. Was there any reason for
 14 that?

15 **A.** No, that was the bed availability at the time. George
 16 was the ward manager for that particular ward but there
 17 is another ward, Newstead Ward, that we would have been
 18 speaking to as well.

19 **Q.** Were you aware at the time that the Priory Hospital
 20 Arnold had been rated inadequate by the CQC?

21 **A.** I became aware of that but I have to contextualise it in
 22 terms of the previous team that I've mentioned about the
 23 performance team and ultimately, whilst I acknowledge
 24 what you're saying there, that is why we did take action
 25 subsequently and did come out of the subcontracted

33

1 "VC is scheduled to be arriving with you early
 2 afternoon. The transport is all booked."
 3 The reply to that, if we scroll up:
 4 "Hi Dave, I believe we have not given you the go
 5 ahead as we have not communicated this with CQC as per
 6 our current arrangement with CQC for every admission,
 7 which bed management are aware."
 8 What did you understand the reference to "CQC
 9 current arrangement" to be?

10 **A.** So at that time I was aware that the CQC did indicate
 11 that they had to agree each movement of the individual
 12 and, to my memory, that had been given for this
 13 individual.

14 **Q.** Right, but as a corollary, you were aware then, at this
 15 time, that the CQC had rated the Priory Arnold
 16 inadequate?

17 **A.** Yes, that makes sense, of course, because they did have
 18 to -- I see your point -- because they did have to pass
 19 every admission through the CQC. So --

20 **Q.** So why did you say earlier you weren't aware of it at
 21 this time?

22 **A.** That's my memory and I can only apologise to you about
 23 that.

24 **Q.** If we go to page 1 and scroll down to that middle email,
 25 we see that the CQC authorisation is obtained and you

35

1 arrangements back to spot purchase arrangements once
 2 things had been improved by that particular hospital.

3 **Q.** When did you become aware of it?

4 **A.** Well, ordinarily, it's outside of the normal context of
 5 a role. I have to be very clear on that. This is held
 6 by performance-related management that assess things and
 7 they did take action as stated, but I did become aware
 8 of it. I can't give you an actual day but within the --

9 **Q.** Before or after this email?

10 **A.** It would have been after. After the e-mail --

11 **Q.** After?

12 **A.** -- because at the time, again, I want to make sure that
 13 everybody is aware that we are trying our best to get
 14 the right bed for the right person at the right time.

15 **Q.** When was it that subcontract was pulled?

16 **A.** I can't give you that information, I'm afraid. I would
 17 wish to, but I haven't got that information. It, again,
 18 isn't part of my actual role. So apologies about that.

19 **Q.** If we could have on screen WITN0389016. If we start
 20 at page 2, please. This is an email chain, so we have
 21 to read it bottom to top. But we can see that
 22 arrangements are being made in respect of that bed at
 23 the Priory Arnold. That email, if we scroll up one more
 24 email, 1st October 2021, 9.16, you send an email to the
 25 team at the Priory saying:

34

1 see they'll be admitting this patient.

2 **A.** Mm-hm.

3 **Q.** Now, in terms of the Bed Management Team being aware of
 4 the Priory Arnold's inspection at that point, its
 5 arrangements with the CQC, did this change your approach
 6 to referrals to the Priory Arnold?

7 **A.** That's a pertinent point. I would just say that
 8 obviously you can see where the confusion came from.
 9 That Ajith Gurusinghe was the actual RC at the time and
 10 so the information that you'd previously seen from
 11 George was that there had been acceptance. We can infer
 12 that --

13 **Q.** That's not my question. My question is, in terms of,
 14 you have a patient like VC, where you need to find
 15 a bed.

16 **A.** Yeah.

17 **Q.** You've got the Priory Arnold on your list. Does the
 18 fact that it's been rated inadequate change your
 19 approach or how you think about admitting that patient
 20 there or referring that patient there?

21 **A.** All I can say is I go on the acuity at the time, the
 22 fact that we had been very happy with the report(?)
 23 previously up to the CQC, you know, situation that was
 24 found at that time and, as I say, there was immediate
 25 action taken by my seniors. But, again, it's a little

36

1 bit outside of my role.

2 **THE CHAIR:** The answer is yes or no. Did it affect your
3 approach to Priory Arnold? Yes or no?

4 **A.** At that time I suppose I have to say no.

5 **MR IVORY:** And did you take any steps yourself or were you
6 aware of any steps taken to satisfy you that the Priory
7 Arnold was a safe place to be referring patients to?

8 **A.** Well, all the time that this was occurring, we did
9 again -- I talked about the performance management and
10 they did make regular -- I do know that they did make
11 regular attendance but I haven't got evidence for you to
12 provide that. I just know the individual, Jenny,
13 herself did attend. And that was part of her role as
14 well, and that wouldn't just be Priory Arnold; it would
15 be all the local providers.

16 **Q.** But you don't know about any specifics, I take it from
17 that?

18 **A.** No. I have to be really honest, no.

19 **Q.** So the answer is no?

20 **A.** Okay.

21 **Q.** Well, I'm asking you.

22 **A.** I think that's a fair point. No.

23 **Q.** Finally, there's two documents I want to go to. In
24 fact, we'll just go to the one. These are the weekly
25 bed management meeting minutes at the Priory. It's

37

1 saw on the first page that meeting was dated 12 October.
2 At the bottom, we see discussion of VC.

3 "Insight limited ...
4 "Presents as quite stable.
5 "Will take a few weeks before he's fully stable.
6 "May take him off the section over the coming
7 weeks."

8 So it appears to be talking about or considering
9 continued admission for at least a few weeks, doesn't
10 it?

11 **A.** Yes, I recognise that.

12 **Q.** But we know in fact VC was discharged just 12 days
13 later. Did you find that surprising at the time?

14 **A.** From a clinical point of view, no. I've got to be
15 contextualise this within the nature of recovery and the
16 fact that mental ill health is known to be on a rolling,
17 as I said, that any one of us can have a settled mental
18 health day and then a day where individual things occur
19 to us that can change things. So I would contextualise
20 what I'm putting there in the nature of the changeable
21 state of an individual's mental state, risk to self,
22 risk to others, et cetera, and that's why, although
23 I put a few weeks before he's fully stable, as for
24 feedback from that particular team, people do get better
25 and can get better and live well in the community,

39

1 WITN0389018.

2 These are meetings you attended, are they? I think
3 we can see your initials.

4 **A.** You can see my initials, yes.

5 **Q.** What's the purpose of these meetings?

6 **A.** So they were to discuss each of our individuals that
7 were on the ward at that time.

8 **Q.** Did you find them useful?

9 **A.** Yes, because it's a way of getting clinical information
10 and that's why we've taken that on to a larger part as
11 we've developed as a Bed Management Team, because you're
12 actually getting direct information that you can pass
13 on. As indicated, you can see CPN involvement in the
14 third column, but it also is a way of bed management
15 oversighting.

16 **Q.** We haven't seen any equivalent meetings or meeting
17 minutes for the Cygnet. Is that because they didn't
18 take place?

19 **A.** There were meetings but, again, I indicate it's with the
20 CCO and there is evidence that CCO Birtles did attend.
21 But, again, we've got to put that in the context of that
22 time, that there wasn't the same expectation as there is
23 now, and became a recognition that we needed to be
24 part of that.

25 **Q.** If we could go to page 5, please. And for reference, we

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1 despite their mental health issues that they have.

2 **Q.** Did you enquire or were you provided information about
3 why that prediction there had changed so quickly?

4 **A.** I have to be absolutely honest, I can't evidence that
5 for you. So no.

6 **Q.** Is that something you think you should have done?

7 **A.** It's -- yeah, it's a definite point and, as I say, from
8 the, you know, all of these things are about learning
9 outcomes and learning from situations --

10 **Q.** Is it something you think you should have done?

11 **A.** Well, yes and no, because of the point that I've just
12 made previously is the fact that people can leave
13 hospital, still with residual elements of ill health but
14 improving and getting better as they go. So it's a
15 tricky one for me to answer, to be honest.

16 **Q.** Could we have that document back up on screen, please,
17 on page 6. And then the last sentence on this entry:
18 "Had a huge hammer with him when first brought to
19 hospital -- we are trying to figure out why he felt like
20 that was needed."

21 Now that is potentially something very significant
22 in terms of the risk VC posed, isn't it?

23 **A.** Yes, I can understand your point.

24 **Q.** Were you ever told why VC had brought a hammer into the
25 hospital?

40

1 A. Well, we got a -- well, we've got to -- well, I would
2 contextualise that within the nature of his psychotic
3 illness at the time, but there are clear evidence of
4 paranoia -- (*overspeaking*) --

5 Q. Were you told a reason of why VC had brought that hammer
6 into hospital after this meeting? Because it looks like
7 the Priory are saying: "We're going to enquire into
8 that."

9 A. Mm-hm.

10 Q. Were you provided with any information as to why?

11 A. I can't remember in that situation, so I have to say no.

12 Q. Did you make any enquiry yourself into, well what was
13 happening there? Have you found out about that?

14 A. On a personal note, I can't say that I did, but I would
15 say that I am working with an MDT and have always worked
16 with an MDT, so that would have been something that
17 could have been taken up. I can't evidence that to you,
18 though.

19 Q. And the reference to a hammer is actually never entered
20 into the RiO notes. It should have been, shouldn't it?

21 A. I can acknowledge that, yes.

22 Q. And whose responsibility was it to do that?

23 A. Again, ultimately at the current time that we're
24 speaking of, that would be the CCO if that knowledge was
25 known, because they'd need to take that back across the

41

1 to do with a visit -- a particular visit that was made,
2 and they put that into their report. It was about a
3 number of different issues that they were concerned
4 about, in terms of patient care.

5 Q. So you know about those issues, and one of them -- could
6 we just have a look at the report by the CQC into the
7 Priory Hospital Arnold and that document is CQCM0016483.
8 If we could please go to page 4 of that. And we see,
9 when we get there, you can see on the front page that
10 "Inadequate" has a red disc on?

11 A. Yes.

12 Q. And we see that the "Summary of each main service" on
13 this page 4 and the red disc, and we see, at the fifth
14 bullet point down:

15 "Staff did not always assess and manage risks to
16 patients and themselves well. The provider had not
17 fully assessed ligature ..."

18 So there were problems with risk assessment in CQC
19 Priory Arnold -- in Priory Arnold, weren't there?

20 A. Yes.

21 Q. And can I just ask you whether or not you were under any
22 pressure, not from Dr Shoilekova and Dr Engel and
23 Dr Nwawueze, but from anywhere else to take VC out of
24 Cygnet and over to some where else?

25 A. Was I under pressure to do that?

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1 whole Community Team in terms of their risk analysis.

2 Q. But you were at this meeting, you have access to the RiO
3 notes.

4 A. Mm-hm.

5 Q. Why is it not your responsibility as well to --

6 A. I acknowledge it is. That wasn't a great answer.
7 I acknowledge it is. And that was a miss, and I have to
8 apologise for that.

9 Q. Because if it wasn't your responsibility, what's the
10 point of you being at this meeting?

11 A. Yeah, it's to pass on relevant information. So it's --
12 I agree with your point.

13 MR IVORY: Thank you, Mr Waldron. I have no further
14 questions.

15 THE CHAIR: Thank you. Yes, Mr Moloney.

16 **Questioned by MR MOLONEY**

17 MR MOLONEY: Good afternoon, Mr Waldron. Just a couple of
18 points if I may, please.

19 You now have accepted in questions that you were
20 aware that Priory Arnold was rated inadequate by CQC and
21 subject to restrictions.

22 A. I acknowledge that, yes.

23 Q. Do you know why it was that Priory Arnold was rated
24 inadequate by CQC and subject to restrictions?

25 A. Yes, I went on to get some insight into that, and it was

42

1 Q. Were you under any pressure from Cygnet to get him out
2 of Cygnet and to get him somewhere else?

3 A. I wouldn't describe it as pressure. I would describe it
4 as that he was just deemed step-down appropriate and we
5 would look for the -- a local bed as soon as we could.

6 Q. Can I ask you to have a look at one more document which
7 is WITN0389011. And if we look at the bottom email of
8 this page, from John Laverick, please, on 29 September.
9 If we could scroll up and focus on John Laverick. Who
10 is John Laverick, Mr Waldron?

11 A. My understanding would be that he would be an individual
12 at Cygnet, because he's copied in the Albert Ward
13 nurses. So he again was requesting his -- yes, he would
14 be a Cygnet colleague.

15 Q. And he's saying to you:

16 "... see the attached information ... sent ... by my
17 colleague Tracey on [23 September 2021] ..."

18 So that's when things are being, as it were,
19 escalated, and your response on 24/9/2021 was as
20 follows:

21 "Thanks Tracey things remain tight for male beds but
22 I am escalating to seniors this morning."

23 That's what comes from you, and then if we go up the
24 page to look at your response to this, which is to Aliya
25 who is the bed coordinator:

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1 "Hi Aliya could you look at sending this to Bestwood
2 if you think I can get VC in tomorrow ..."
3 Bestwood is a ward at Priory Arnold, isn't it?
4 **A.** It is, yes.
5 **Q.** "... I'm conscious of taking a bed but the cygnet team
6 are getting a little bolshy and George at Bestwood said
7 he could take a look at it if you're ok to send it on".
8 Could you explain that the "cygnet getting a little
9 bolshy" meant in that context?
10 **A.** They had asked for a number of times to step VC down,
11 and I've already apologised for my language used at this
12 particular entry, but to state that is the pressure that
13 remained from the team themselves to push the step down.
14 **Q.** So there was pressure to push the step down?
15 **A.** There is always pressure.
16 **Q.** Absolutely.
17 **A.** I have to really be very clear to everybody, within the
18 nature of the team.
19 **MR MOLONEY:** Thank you very much, Mr Waldron.
20 **THE CHAIR:** Yes, thank you.
21 **THE WITNESS:** Thank you.
22 **Questioned by MS CARTWRIGHT**
23 **MS CARTWRIGHT:** Good afternoon, Mr Waldron. I ask questions
24 on behalf of the survivors.
25 Can we go back to the dashboard for the 4 September,
45

1 PICU appropriate, you can see from the earlier page that
2 that bed was not available.
3 **Q.** You don't address that, though, at all in your
4 statement. But let's then go back to the first page
5 because there were also contracted PICU beds available,
6 and so can we look, please, at the PICU beds available
7 at the Littlemore. So we can see that we've got PICU
8 beds, "Littlemore PICU -- 5 3 beds available", so
9 again, within the area?
10 **A.** Yeah, just to explain, they're all female beds.
11 **Q.** They're all female.
12 **A.** Yes.
13 **Q.** Then if we look at Rufford then, at the PICU Priory
14 Arnold, "5 ... 2 beds available".
15 **A.** Yes.
16 **Q.** But that is a male PICU, would you agree, at the Priory
17 Arnold?
18 **A.** In my recollection at that time no, it's just Willows is
19 the male, all male --
20 **Q.** And that's your evidence on oath --
21 **A.** It is.
22 **Q.** -- that there are female PICU beds.
23 **A.** Yes.
24 **Q.** And your evidence is -- let me be clear: is it your
25 evidence that VC was assessed for the Willows, and they
47

1 please, which is the WITN0389003 document, please.
2 Thank you. You've already gone through the various --
3 what this table shows. So we can see this is for
4 4 September 2021.
5 **A.** Mm-hm.
6 **Q.** So it's the day after VC has been sectioned pursuant to
7 the Mental Health Act, which happened on 3 September.
8 But let's look at Willows, which was your PICU at
9 Highbury Hospital, a local hospital. There was one bed
10 available, and if you look over the page, please, we can
11 see that for VC:
12 "PICU Referral will be sent for gatekeeping by
13 Dr Lomas and has been accepted by Willows."
14 So there's a bed at the Willows and he'd been
15 accepted by the Willows. So why was VC not transferred
16 from essentially an inappropriate bed on a Section 136
17 suite where he was being held in seclusion, to that
18 available local PICU bed?
19 **A.** Yeah, I think there's a bit of a miscommunication there
20 because it's -- the referral has been gate kept by
21 Dr Lomas and has been accepted. Willows are the
22 gatekeeping team for PICU.
23 **Q.** Yes.
24 **A.** Every single one goes through that. And so just to
25 indicate that although it does state that he would be
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1 declined to accept him on the PICU?
2 **A.** No, it's not; it's as I say, they did look at the
3 gatekeeping for VC. They then stated he was PICU
4 appropriate and, as indicated, they didn't have a bed
5 available at that time.
6 **Q.** All right. You've only provided the dashboard for
7 4 September, and we know again that VC stayed at the
8 Section 136 suite which is essentially it's the referral
9 for the police to use those beds.
10 **A.** Mm-hm.
11 **Q.** And so why have you not provided the dashboard for every
12 day up until 11 September, bearing in mind PICU
13 discharges happen on a daily basis? So why have we only
14 got 4 September?
15 **A.** Well, you haven't, in my -- okay, I can acknowledge, you
16 haven't actually sent the dashboard as it is, but it is
17 indicated in my evidence that there were no changes to
18 Willows at that time.
19 **Q.** Can we then go back over the --
20 **A.** It is in my evidence.
21 **Q.** -- page again to the entry for VC. We can see it
22 references:
23 "Not for [out of area] ... bed, p[atien]t and family
24 decline this."
25 So that's recorded on the notes. So if that's
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1 what's the indication that VC shouldn't have been for an
2 out-of-area bed, why were you -- essentially, was he
3 moved to an out-of-area bed?

4 **A.** Because of the nature of things not changing on the
5 Willows Ward at that time. Ultimately, as indicated
6 previously about the 136 not being the suite, not being
7 an appropriate environment, we did have to, and
8 sometimes have to, overrule our own requests that are
9 made by individuals to provide --

10 **Q.** Thank you. If we could go back, then, to page 1 so I'm
11 absolutely clear the Trust's position at the time.

12 So in respect of the available PICU beds for males
13 in Nottingham as at September 2020, is it your evidence
14 that there were just nine available PICU beds and all
15 the rest were female?

16 **A.** Yes.

17 **Q.** All right.

18 **A.** And that remains true, apart from the fact that we've
19 now got spot purchase beds in the local area at another
20 hospital.

21 **Q.** Right.

22 **A.** Which would be described as an out-of-area hospital but
23 is in the locality of Nottingham.

24 **Q.** Now you were asked questions about the Priory and the
25 CQC rating from March of 2021. But can I take you to

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1 They continued to remain inadequate and, in fact, the
2 subsequent inspection in December again put them into
3 special measures.

4 So what scrutiny were you undertaking of the
5 discharge documents that the Priory provided you and
6 also checking that they had undertaken a safe discharge
7 of a patient?

8 **A.** Yes, as stated, at the time it is acknowledged that the
9 Continuity of Care Principles would be for the CPN and
10 the CCO to receive that discharge document. Yes, we did
11 receive it but it was received by the CPN as well that
12 uploaded that. So --

13 **Q.** But that's not the question. The question is this
14 document says he was discharged 24th October, but the
15 RiO notes show that he's been discharged on 22nd October
16 without anybody's knowledge and he's back home without
17 any checks on his accommodation or any package of care
18 being put in place.

19 So were you aware of that? What did you do about
20 it?

21 **A.** Well, as stated, I personally wasn't aware of that. My
22 understanding was, possibly because I wasn't in at that
23 time, but for not making any excuses at all, my
24 understanding was there was still a three-day follow-up
25 in place and one of the things that has changed is we

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1 the discharge document that you provided when VC was
2 discharged from the Priory, which is CHCA0000014. Thank
3 you.

4 You tell us in your witness statement that this was
5 the discharge document that the Priory provided to you.
6 And we can see the date of the discharge was 24 October
7 that's recorded on this document.

8 Now, we already know that you had access to the RiO
9 notes, and in providing your statement you've referenced
10 entries from page 191 and 192 of the RiOs but not 193.
11 So can I ask you first of all: were you aware of the
12 entry in the RiO notes for 22 October that by
13 22 October, VC was already back home, had been
14 discharged without any notification to the Local Mental
15 Health Team, so essentially, they -- they're entered in
16 the RiO notes for 22 October that VC is back home. So
17 were you aware of that?

18 **A.** I was -- yeah, but I was aware that he did have the
19 three-day follow-up in place and that did occur with the
20 CCO. So I'm a bit bemused by that one.

21 **Q.** But were you aware that there was an issue linked to
22 this discharge? Bearing in mind you received the
23 Discharge Summary, would you agree that the Priory at
24 this time was subject to inadequate rating with the CQC?
25 You had to be given permission to place somebody there.

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1 used to do a seven-day follow-up that was found to be
2 inadequate. So we, like many trusts, had brought it
3 down to three days and that did take place. So, yeah,
4 I'm -- that's all I can say on that one.

5 **Q.** Well, can I just be absolutely clear because, on one
6 view, a patient being discharged from a private provider
7 where you've contracted for beds where they've not
8 followed policies and procedures so everyone is aware,
9 and there's a safe discharge of a schizophrenic patient
10 would flag issues of, would you agree, contractual
11 compliance, patient safety, and, potentially, a Datix
12 incident being needed.

13 So can I be clear, were you aware of the issue
14 linked to the Priory discharge on 22nd October?

15 **A.** No, I have to say at that time, no.

16 **Q.** When did you become aware of it?

17 **A.** As of when -- you know, it would have been back in work
18 and seeing that but, by that time, I do know that the
19 three-day follow-up was supported.

20 **THE CHAIR:** I think you've just been asked when you knew it.
21 When did you know it?

22 **A.** I can't give a date, I apologise.

23 **THE CHAIR:** You can't remember. Was it three days after, or
24 what?

25 **A.** I can't indicate that to you. So apologies.

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1 **MS CARTWRIGHT:** So can you help us then, bearing in mind
 2 your witness statement doesn't deal with that issue
 3 whatsoever, has dealt with page 191 of the RiO notes,
 4 192, you've received the Discharge Summary, you've
 5 exhibited it but you have failed in your witness
 6 statement, that's said to be your honest and accurate
 7 account to this Inquiry of all relevant evidence, why
 8 have you omitted to deal with this highly relevant,
 9 important information around what is, on any view, an
 10 unsafe discharge of a patient who's been on a Section 3
 11 back into the community with no notice to the Community
 12 Team?
 13 **A.** Well, as I say, I have to be completely honest about
 14 this. I saw that at the time, whenever that was that
 15 I saw that the three-day follow-up had been done, I have
 16 to acknowledge that I hadn't really -- I can't, I can't
 17 really explain that, because, you know, that was my
 18 knowledge at that time and that was why I was being
 19 honest and open about that situation.
 20 One thing I can say to everybody in this room is
 21 that we do now ensure, from the bed management
 22 perspective, that whereas that was the previous
 23 practice, that it would go to the LMHT, to the CPN or
 24 whichever Community Team that there was, we now make
 25 sure, and we do, and I can personally vouch for myself

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1 **THE CHAIR:** Is it not something that caused you concern?
 2 **A.** In --
 3 **THE CHAIR:** It says a very large hammer.
 4 **A.** On reflection, yes.
 5 **THE CHAIR:** Did you write that?
 6 **A.** Did I write that?
 7 **THE CHAIR:** "Very large hammer" in the note or was it
 8 somebody else?
 9 **A.** No, that would have been provided by the --
 10 **THE CHAIR:** Provided to you.
 11 **A.** Yes, and that's why Priory Arnold did follow that up, to
 12 the best of my knowledge. I do apologise to everyone
 13 about missing --
 14 **THE CHAIR:** You're aware that the CQC, who you had to
 15 contact in relation to beds, were concerned. Did you
 16 inform the CQC about it?
 17 **A.** I personally didn't, no.
 18 **THE CHAIR:** Why not?
 19 **A.** Why not? Again, it would have been escalated within our
 20 DDMs, the daily demand meetings, and so that would fall
 21 upon all of us. So I just have to apologise. No,
 22 I didn't take part in acknowledgement of the point
 23 you're making.
 24 **THE CHAIR:** And did you escalate it personally within your
 25 meetings?

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1 and my team, that we do follow these three-day
 2 follow-ups as well to ensure that they have occurred.
 3 **Q.** Then, I'm not going to go through this --
 4 **THE CHAIR:** No, Ms Cartwright, you're again, I'm afraid,
 5 over time.
 6 **MS CARTWRIGHT:** Just one very briefly on that page. We can
 7 see that VC's car was parked at Highbury Hospital. We
 8 know he didn't drive to Highbury Hospital when he was
 9 detained on his section -- on the Section 135, 136. So
 10 can you help at all as to when VC collected his car and
 11 drove it to the Highbury Hospital, which was being
 12 addressed in this, at a time, on any view, where he must
 13 have been very unwell?
 14 **A.** Yes, I can't answer that question. I apologise.
 15 **MS CARTWRIGHT:** Thank you.
 16 Thank you, Chair.
 17 **Questioned by THE CHAIR**
 18 **THE CHAIR:** Can I just ask about the hammer.
 19 **A.** Mm-hm.
 20 **THE CHAIR:** You knew that Priory Arnold at that stage were
 21 considered to be inadequate. Did you think about
 22 following that up and making sure that was something
 23 that was dealt with properly?
 24 **A.** I think that's a fair comment and I apologise that that
 25 didn't happen from myself.

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1 **A.** I don't believe I did.
 2 **THE CHAIR:** No, thank you.
 3 Right. Well, we'll take a break now, I think, until
 4 3.20.
 5 **(3.07 pm)**
 6 **(A short break)**
 7 **(3.20 pm)**
 8 **MS LANGDALE:** Chair, may I call, please, Dr Taylor.
 9 **THE CHAIR:** Yes.
 10 **DR MARK TAYLOR (sworn)**
 11 **Questioned by MS LANGDALE**
 12 **MS LANGDALE:** Dr Taylor, could you tell us your
 13 qualifications, please.
 14 **A.** I have a primary degree in medicine and, in addition to
 15 that, I'm a Member of the Royal College of
 16 Psychiatrists. I also have a Certificate of Completion
 17 of Higher Training in Forensic Psychiatry .
 18 **Q.** And you've prepared a statement for the Inquiry dated
 19 10th February 2026. Can you confirm the contents are
 20 true and accurate, as far as you're concerned?
 21 **A.** I can confirm that, Ma'am.
 22 **Q.** And you set out at paragraph 7, you were Clinical
 23 Director of NHFT's Low Secure and Community Forensic
 24 Care Unit between 2015 and 2021; is that correct?
 25 **A.** That's correct.

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1 Q. And since 2021 you've been an Associate Medical Director
2 in the Forensic Services Care Group?

3 A. That's correct.

4 Q. Can you tell us, please, the difference between
5 a forensic psychiatrist and a general psychiatrist, in
6 terms of assessing risk?

7 A. So a forensic psychiatrist will have undertaken
8 specialist training in forensic psychiatry, generally
9 speaking, and that will involve placements in a variety
10 of different secure environments, so high, medium, low
11 and community forensic, as well as in prison settings.

12 In the context of that training, they will have seen
13 patients from a variety of different -- with a variety
14 of different presentations and they will be experienced
15 particularly in risk towards others. And that will
16 dictate some of their assessing skills, in terms of
17 being able to admit patients to secure services, or to
18 give advice in terms of existing patients and their
19 care, or to manage patients in alternative settings such
20 as community environments.

21 Q. Are they well equipped to detect masking of symptoms and
22 not taking what patients say at face value? Are they
23 better equipped in that respect than general
24 psychiatrists?

25 A. I'm not sure that they're better at doing that, per se.

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1 to treatment, and at the point at which you feel that
2 that is proportionate and reasonable as the next step to
3 make.

4 Q. Can we have, please, paragraph 9 of your statement on
5 the screen which is WITN0388001, page 3, please. You
6 set out in your statement how you were contacted by the
7 L&D Service Manager at some stage on 13th June 2023 on
8 the day of the attacks. You set out here -- well, tell
9 us what you set out here.

10 A. So on that day I identified myself out as a relevant
11 point of contact for the Liaison and Diversion Service
12 Manager and Operational Manager within that service.

13 Having been aware that there was a potentially
14 high-profile person in custody, I identified myself, and
15 also the Clinical Director, as key points of contact if
16 there was strategic advice and support needed, in terms
17 of the pathway for that patient.

18 Q. And in terms of what you say here, you say:

19 "It was unclear whether the L&D Service Manager was
20 asking about early diversion to hospital. This is
21 something that may occur in a case of low-level
22 offending. In my experience, for high-level offenders
23 it would be more usual to charge and remand the patient
24 to custody ..."

25 Can you just tell us what the distinction is?

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1 But what I would say is that in forensic psychiatry we
2 often have the benefit of knowing patients for much
3 longer periods of time. So, for example, we might have
4 a case load of inpatients who we are responsible for who
5 we know for a period of many months, or even years, and
6 the purpose of part of that role as a psychiatrist is to
7 elicit symptoms, to understand and recognise a patient's
8 response to treatment over a period of time, and be
9 curious about their mental health and risk behaviour.

10 Q. And what's the benefit of having continuity of time and
11 treatment for a patient?

12 A. The benefit is that you can see some of those changes.
13 Hopefully, not necessarily all the time, but even if
14 you're not seeing changes, that's still telling you some
15 information about that patient's risk and about their
16 likely future pathway. You will then know the patient
17 well, and you will feel in a much better informed place
18 to be able to make some decisions in the future where,
19 for example, you are seeking to provide more autonomy
20 for the patient.

21 So, for example, in an inpatient forensic care
22 pathway you might be considering the introduction of
23 more access within the hospital or leave in the
24 community. Those are really key and complex decisions,
25 and you need to understand the case well, their response

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1 A. Yes, I can. Yes, Ma'am. So in custody and in custodial
2 settings, there's a -- patients could be diverted into
3 mental health settings at a range of different points in
4 that criminal justice pathway. It need not occur at the
5 earliest possible opportunity, which would have been
6 then. For me at that point in time, the key issue was
7 the patient's fitness to be detained and to be
8 interviewed by the police, and so that was the issue
9 that I highlighted as being the key one for the MITIE
10 clinicians to consider.

11 Q. We'll go to the emails on the specific considerations
12 but in terms of here you say "high-level offenders, more
13 usual to charge and remand the patient to custody", do
14 you mean that they wouldn't therefore be assessed by
15 MITIE? They'd be remanded to custody and assessed at
16 a later time?

17 A. What I mean is they would have that fitness to be
18 interviewed process would occur. The -- providing that
19 was achieved and that they were fit to be detained and
20 to be interviewed and that was the conclusion by MITIE,
21 further to reassessment by a different clinician, when
22 that had been achieved and they would then potentially
23 be charged by the police and remanded into custody
24 through the courts.

25 And we have -- there's a process by which

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1 recommendations are then made to the courts to then help
2 and to guide the pathway thereafter, and there's also
3 information exchange can then be provided to the
4 receiving mental health team in prison to ensure that
5 they're appropriately equipped and can continue that
6 assessment of the patient's mental health needs whilst
7 in custody.

8 **Q.** And as far as you're concerned, where there's high-level
9 offending, when would the first mental state
10 examination, not simply fitness to be interviewed or
11 detained, but mental state examination, occur?

12 **A.** Well, I mean mental state examinations could be
13 undertaken by a range of different clinicians, and so
14 that mental health assessment, as is documented in
15 records, is important, in terms of building up a picture
16 of that patient's mental health needs.

17 I appreciate that the level of training and
18 expertise of the individual concerned will differ, and
19 that that's not a psychiatrist doing that assessment,
20 necessarily. But a mental state examination does give
21 you a point of reference at a stage in time.

22 **Q.** And what's the significance of having it at a particular
23 stage in time?

24 **A.** Because you can build up a picture of the emerging
25 mental state picture over a period of time. So, you

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1 but at the same time they would probably say that they
2 were unable to assess that fully and that they'd
3 therefore need to assess more fully in future.

4 So in other words how definitive that assessment
5 might be would, I guess --

6 **Q.** That's a different point. It's the level of
7 instruction, isn't it?

8 **A.** Yes.

9 **Q.** What would the psychiatrist be asked to do?

10 **A.** Yes.

11 **Q.** Have you ever been briefed or instructed to examine
12 somebody in custody?

13 **A.** I have assessed somebody in --

14 **Q.** At the time of offences?

15 **A.** Yes, I have.

16 **Q.** At the time of serious offending?

17 **A.** Yes.

18 **Q.** And what was the brief, as it were? What was the
19 purpose of you undertaking that investigation or
20 examination, rather?

21 **A.** It was about whether the patient had a diagnosable
22 mental disorder and what the extent of that was, and
23 therefore what -- whether there were any diversion was
24 necessary at that point in time.

25 **Q.** Was it a serious, grave offence?

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1 know, for example, I've heard in the Inquiry some
2 reference to an evidential assessment, as such, in
3 custody, and I think the difficulty, perhaps, with that
4 concept --

5 **Q.** What do you mean by an evidential assessment?

6 **A.** Sorry?

7 **Q.** When you say you've heard in the Inquiry about an
8 evidential assessment in custody, what do you mean by
9 that?

10 **A.** Yes. Well, I think I heard in evidence earlier in the
11 Inquiry some -- a discussion about that topic.

12 **Q.** A forensic psychiatric examination of the offender close
13 to the time of events; is that what you're referring to?

14 **A.** Yes. I am, Ma'am, yes.

15 **Q.** So what is the value in having an assessment, a forensic
16 assessment of mental state, close to the time of the
17 events?

18 **A.** So the value might be that you are able to put together
19 a detailed mental health assessment of that patient at
20 that point in time. There are, though, difficulties in
21 terms of the consent for that process. There are
22 caveats in terms of the -- what the psychiatrist might
23 assess. So in other words they might be likely to say
24 that the patient wasn't communicating very much, they
25 weren't -- there wasn't evidence of overt symptomology,

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1 **A.** It was a serious offence.

2 **Q.** So who contacted you to do that?

3 **A.** The police contacted me to do that, but that was about
4 I think between -- maybe about 15 years ago now.

5 **Q.** 15 years ago --

6 **A.** Yes, it was -- (*overspeaking*) --

7 **Q.** So we've heard of that system, Dr Blackwood referred to
8 that, where effectively a forensic psychiatrist could be
9 brought into the police station at the time as someone
10 was capable of being interviewed, detained, but to
11 assess their mental state. So you've had that
12 experience too?

13 **A.** I have, yes.

14 **Q.** And where an offender has a history of mental health
15 services, indeed it's wise to conduct an assessment at
16 that point, isn't it, to understand around the time of
17 the offences what the mental state appears to be, albeit
18 that you may need more records, more detail later on,
19 but that that's a good time to do it?

20 **A.** Well, my position, when I was giving advice in relation
21 to this case, was that fitness to be interviewed and to
22 be detained was the key issue, in terms of the patient
23 then being charged, remanded in custody, and then follow
24 a forensic pathway to hospital. If that was what was
25 felt appropriate, based on the assessment of the patient

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1 and their needs. So that was the position I took at
 2 that --
 3 **Q.** Let's have a look at the email, shall we. WITN0388015,
 4 page 2. This is the first in a chain, surrounding, if
 5 we look at the top, if we go to page 2 first.
 6 "... spoken to ... Matron ... [and] confirmed no
 7 S[ection]17 in ... the City Centre.
 8 "... spoken to Fiona ... alerting community staff
 9 and requesting no staff/patient community contacts
 10 within the city centre vicinity."
 11 To be clear, 13 June, the city centre was locked
 12 down, wasn't it, large parts of it.
 13 **A.** Yes, that's correct. Yes, it was.
 14 **Q.** Everybody understood from the news, the nation, it was
 15 on the news.
 16 **A.** Yes.
 17 **Q.** You of course had seen that and at the time of these
 18 emails were aware of that.
 19 **A.** Yes.
 20 **Q.** If we go over to page 1, please. From Jackie Chapman to
 21 yourself and others:
 22 "[Yes] That's great thank you."
 23 And if we go up to the top, you say:
 24 "Thanks all. I can't imagine it will arise, but
 25 given the high profile nature of the situation, if
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1 that email refers to and it was obviously in the context
 2 of the discussions you'd had earlier, presumably over
 3 Teams meet?
 4 **A.** Yes, it was. So this was about the fact that because
 5 there'd been some concerns about the initial assessment
 6 of VC, in terms of his fitness to be detained and to be
 7 interviewed, and that may have then been connected with
 8 potential diversion at that stage, therefore I had
 9 suggested, through our Liaison and Diversion Manager,
 10 Ms Hagan, that this be escalated within MITIE. So MITIE
 11 obviously do the medical interventions into custody, to
 12 a senior clinician such as a forensic physician, or
 13 a senior colleague, as well as within their leadership
 14 structure.
 15 And because I was aware of the PACE police clock
 16 overnight, I was also aware that, you know, it may not
 17 be that we could wait for the result of some of that
 18 process for the next morning, so I needed to hand over
 19 that information to the senior colleagues who were on
 20 call overnight.
 21 So Kazia and Jo-Anne are those senior colleagues who
 22 were covering the Trust out of hours at a senior level.
 23 And what I was to saying was, could we try to keep this
 24 decision-making and consideration within those who had
 25 already led it thus far.
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1 mental health issues/diversion is raised (man in custody
 2 on suspicion of 3 murders), and L&D colleagues need
 3 support/advice, then [you] ... can be contacted
 4 according via Fiona."
 5 I'm not sure if that time of your email is the right
 6 time or not, but either way that looks as though it's
 7 earlier than the other ones I've referred to in the
 8 chain.
 9 There's a communication going on between you and
 10 others at this point.
 11 **A.** (*The witness nodded*).
 12 **Q.** So what was the potential need for involvement that you
 13 were identifying at an early stage for forensic
 14 services?
 15 **A.** Well, it might have been if there had been any -- if the
 16 issue had been raised about fitness to be interviewed,
 17 or for diversion to hospital. Those were the two key
 18 areas I was thinking about, Ma'am.
 19 **Q.** If we go, please, to WITN0388013, page 2. If we see at
 20 page 2, you've had a Teams meet, a number of you,
 21 I think, at 5.15-5.45 on 13 June. And then we see if we
 22 go to page 1, you set out in the email what's discussed
 23 earlier at the bottom of the page, please:
 24 "Dear Kazia and Jo-Anne ..."
 25 That can go up, can you tell us what the context of
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1 **Q.** What was your understanding of why MITIE had requested
 2 the involvement of L&D, Liaison and Diversion?
 3 **A.** Well, in terms of Liaison and Diversion at that point in
 4 time, I can't recall that exact -- that part of the
 5 dialogue. As I say, my recollection was that this was
 6 about concern about his fitness to be interviewed and to
 7 be detained.
 8 **Q.** So why did you think a forensic physician would likely
 9 be involved if it was about fitness to be detained?
 10 **A.** Because that's an area that they have a lot of expertise
 11 in. I subsequently realised or became aware that they
 12 don't currently have a forensic physician in that
 13 service, but I was aware that they -- but they do have
 14 a Medical Director, and I think Ms Draper referred to
 15 that in her evidence earlier to the Inquiry, that she
 16 could have highlighted to them, if she'd wished to, and
 17 equally, I would have been happy to have had that
 18 discussion with that person -- with the Medical Director
 19 too, about how we progressed if there were still
 20 concerns about his fitness to be detained and to be
 21 interviewed.
 22 **Q.** You say at the bottom:
 23 "... in case of contact to the Trust from the
 24 provider as they are 24 hours ..."
 25 What contact with the Trust was envisaged? Was that
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1 discussed?

2 **A.** No, what it means is in case there was any further
3 dialogue overnight, because I knew that neither Kazia
4 nor Jo-Anne had any input to this, nor any particular,
5 you know, background in this area I was suggesting that
6 they sort of essentially could contain the situation as
7 much as is feasible, such that we could take over that
8 situation again the next morning and that's why I then
9 subsequently sought to find out from Ms Hagan what had
10 developed overnight.

11 **Q.** In what circumstances did you think you would need to be
12 taking over? Where they were unable to say whether he
13 was fit to be interviewed and detained and needed expert
14 assistance with that?

15 **A.** Yes, that may well be the case.

16 **Q.** You say it may well be the case. Is that what you were
17 thinking of here?

18 **A.** That's what I was thinking, was whether we would need to
19 support in terms of that process because even, though
20 that is a function that MITIE does as part of its role,
21 providing medical interventions into custody,
22 I recognise that psychiatrists can also assist in that
23 process.

24 **Q.** And the email at the top of the page, please, if we can
25 go to that one. 18.32, you say:

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1 a forensic psychiatrist but they're still part of the
2 wider healthcare team.

3 **Q.** Can we have, please, WITN0388016, page 2, an email from
4 Louisa Hagan on 14th June, page 2. So Ms Hagan is
5 saying:

6 "I've spoken with Aaron in custody, nothing has come
7 in overnight, nothing asked of them so far ... I've
8 asked just to be contacted if this changes so will let
9 you know."

10 If we go to page 1, you respond at the bottom of
11 page 1, please:

12 "Thanks Louisa. So as far as police processes are
13 concerned, are there outstanding concerns re fitness to
14 be detained and interviewed, or not? We asked that
15 MITIE reassess with a more senior clinician. What was
16 the outcome to this? Clearly I don't want us to be
17 involved if not necessary but equally not knowing risks
18 police approaching us to advise as to the definitive
19 position?"

20 What did that mean "equally not knowing risks police
21 approaching us to advise" --

22 **A.** Because there could always be circumstances where other
23 agencies, such as the police or I guess the CPS, could
24 approach us directly, and we wouldn't necessarily know
25 what MITIE's position was.

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1 "I hope [the] ... position is resolved and there is
2 no further approach with a view to diversion ... If not,
3 we will need to pick up again.

4 "... if expert psychiatric assessment is needed due
5 to no resolution, I would likely be better-placed
6 overseeing this exercise and supporting the outcome at
7 Trust level, rather than conducting it myself (though
8 I do have experience of these situations). Have a think
9 about other options ..."

10 What were you suggesting there?

11 **A.** What I'm saying there is that, you know, I'm hoping that
12 the reassessment of fitness to be interviewed and
13 detained concludes that he is fit to be detained to be
14 interviewed, and that therefore that then follows
15 through such that the police seek to charge him, and
16 then we could follow that pathway into prison.

17 **Q.** And that does result in a delay, doesn't it, for mental
18 state examination? He went into prison, we know that.
19 He was seen by a forensic psychiatrist in a prison later
20 on.

21 **A.** Well, I mean, the MITIE clinicians were still doing
22 a mental state examination when they were assessing him
23 and deciding on his fitness to be interviewed and to be
24 detained. I appreciate that, as I alluded to earlier
25 on, you know, that may not be to the same standard as

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1 **Q.** But it's suggesting "not knowing risks police
2 approaching us". Does that suggest you didn't want to
3 be involved in this way?

4 **A.** Oh no. Gosh, no. What it means is that, you know, we
5 should be working collaboratively with MITIE in this
6 sense. That's what it means, Ma'am.

7 **Q.** And we see at the top email, Louisa Hagan:

8 "I've had a quick chat with staff this morning.
9 Sergeant said he's potentially likely to be in custody
10 for a further two days. They have plans to interview.
11 He remains responsive but non-verbal. No immediate
12 worries re presentation -- nothing to suggest he is
13 unwell but he is not talking (nodding understanding and
14 able to get immediate needs known)."

15 Did being non-verbal but described as not unwell
16 strike you as anything out of the ordinary or not?

17 **A.** I think it's difficult to know because clearly I didn't
18 assess him at that stage.

19 **Q.** If we can have, please, WITN0388014, page 1. And we see
20 here you had set up a meeting, 15th June at the bottom.
21 You tell us about this in paragraph 11 of your
22 statement. A meeting had been set up, hadn't it, with
23 Rampton Hospital clinicians in case an urgent need for
24 secure assessment was required? Is that right?

25 **A.** Yes, that's right.

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1 Q. So you anticipated that. You thought that might be
2 needed, expert assessment, early on?
3 A. Well, that was specifically if there was no -- if there
4 was essentially no other option but than to divert him
5 urgently, you know, as an emergency, under civil Mental
6 Health Act legislation, into hospital. And I was aware
7 that if he was going to go to hospital, it would need to
8 be conditions of high security.
9 Q. So you meant if there was a Mental Health Act Assessment
10 and he needed to go to hospital?
11 A. If he -- as I said previously, my position at the time
12 was that -- for me, the critical issue was his fitness
13 to be detained and to be interviewed, and that should
14 dictate the pathway, and that there are future options
15 for diversion through use of forensic sections. That
16 was the ideal route that I could perceive happening.
17 However, I was also aware that his mental state may
18 change whilst in custody, or there may be concerns
19 raised by other agencies that may ask us to reassess
20 that position and reconsider it.
21 I was also aware, though, that to seek to admit to
22 Rampton Hospital would be potentially of concern, one,
23 because of the Trust situation and, two, because --
24 well, because of the reasons that I've alluded to in my
25 letter to NHSE.

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1 A. Yes, that's right.
2 Q. And you request, if we can have WITN0388018, page 1,
3 please -- you refer to the position and what are you
4 suggesting there at the third paragraph of the letter?
5 A. So I'm asking for mutual aid from the other high secure
6 hospitals. So this is a process by which the three high
7 secure hospitals in England can work together,
8 specifically in terms of waiting list management, new
9 referral activities such as this, or existing patients
10 that they have who may be best placed in one of the
11 other three hospitals.
12 And so I set out the rationale for that, and, you
13 know, that was on the basis, one, of the fact that we
14 knew, I think, by that stage that the patient had had
15 contact with the Trust. We also knew that sadly one of
16 the victims had been a medical student and that there
17 are medical and nursing students who have placements at
18 Rampton Hospital and we thought it would be insensitive
19 for him to be admitted there.
20 Q. And page 2 for the end of the letter for completeness
21 for people to see.
22 We know that Dr Milton conducted an assessment on
23 12th August. He said he wasn't allowed to take in his
24 preparation notes and he had no access to the patient
25 records at the time. I think he referred to them being

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1 Q. If we look at the top of this page, please, you say:
2 "You can stand down that meeting. We've seen on
3 BBC News the detained person has been charged with
4 murder and is due to appear before Magistrates' Court.
5 Thank you for the meeting."
6 You say, "We all worked well as a team". Just so
7 I understand, what was your role? Were you working for
8 the Trust in this context or supporting MITIE? What was
9 your role in these communications?
10 A. I'm sorry, which --
11 Q. These here. With the group that you're talking about,
12 he's on the news --
13 A. So this group of clinicians are clinicians at Rampton
14 Hospital. So ... and Adele Fox was the then Care Group
15 Director, John Wallace the then Rampton Clinical
16 Director, and the other two colleagues are forensic
17 psychiatrists at Rampton Hospital. Mary Di Lusto was
18 then Interim Associate Medical Director there at that
19 point.
20 Q. If we go, please, to WITN0388017, page 1, we see, in
21 July 2023, 24th July:
22 "Rampton Hospital received a request from HMP
23 Manchester that VC be assessed with a view to transfer
24 to high secure care."
25 That's right, isn't it?

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1 embargoed. He was under the impression they were
2 embargoed.
3 Is that typical, in your experience, when going to
4 assess a patient in these circumstances, or similar
5 circumstances?
6 A. It can be that if going into a high secure prison that
7 that could be the case. I guess that's something that
8 I have experienced, but not frequently. I don't tend to
9 go into high secure prisons because I work in low secure
10 conditions, clinically. But where it does happen, you
11 know, it's not something that I think is appropriate.
12 I think you need to be able to take the notes in and
13 I hope that he escalated that with the prison.
14 Q. That can come down now, please.
15 We know, of course, that VC was arrested on
16 13th June and Dr Ullal saw him on 27th June and
17 11th July in prison. Given the offences and his history
18 of mental illness, do you agree he should have been
19 assessed by a forensic psychiatrist sooner? It would
20 have been better for him to be assessed
21 contemporaneously for mental state?
22 A. I think I can understand that there may be different
23 views on this point. I think at that time I did what
24 I thought was the appropriate course of action in terms
25 of focusing on the area of his fitness to be detained

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1 and to be interviewed in the first instance, in the
2 knowledge that we could then provide that clinical
3 handover, that information exchange about his past
4 clinical history to the next area, which would be in the
5 Prison Healthcare Team.

6 That said, I acknowledge that, for example, the way
7 that that was documented in the healthcare record wasn't
8 ideal. It wasn't -- they didn't summarise the situation
9 in the way that I would have preferred it to have been
10 summarised, and it didn't summarise the complexity of
11 the discussion that we had about that theme,
12 unfortunately.

13 I do support two of the points that Ms Hagan made in
14 relation -- first of all, in relation to Liaison and
15 Diversion could have offered her a reassessment or --

16 **Q.** Could have ...?

17 **A.** Offered a reassessment of VC whilst he was in custody.

18 **Q.** By a psychiatrist? A forensic psychiatrist?

19 **A.** Well, by the L&D team in the first place.

20 **Q.** But if he wasn't going to be diverted, they may not have
21 done that. But they had access, from what we've seen,
22 to independent forensic psychiatrists if they'd wanted
23 to, if they thought that was appropriate?

24 **A.** Sorry, L&D could have done that?

25 **Q.** Yeah.

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1 that situation, to make no comment and will be guarding
2 their position --

3 **A.** Yes.

4 **Q.** -- in the context of the criminal law.

5 **A.** *(The witness nodded).*

6 **Q.** For the victims, who want justice and to see what's
7 happened and to understand why what has happened has
8 happened. And then you as a professional, presumably as
9 a forensic psychiatrist, do what you're instructed to do
10 in a particular context. You wouldn't necessarily bring
11 a view to which you think was more important about those
12 things, would you -- or would you?

13 **A.** I don't know if I would bring a view to that *per se*, but
14 what I think is important is that there's some clarity
15 set out as to what that assessment would be seeking to
16 achieve, what its purpose was, how it was documented,
17 the consent process.

18 **Q.** What's the consent process? What do you mean by that?

19 **A.** Well, in terms of the fact that if you're seeing -- when
20 you're seeing a patient, you see the patient with a view
21 to a particular function, you know. So if you were
22 seeing them with a view to considering their
23 detainability under the Mental Health Act, or with
24 a view to the availability of treatment interventions,
25 in this context, we would -- I guess all I'm saying is

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1 **A.** Well, I was in an ongoing dialogue with Ms Hagan, and if
2 there had been circumstances where I felt that was
3 necessary, then that is something that I could have
4 facilitated. But at that point in time I didn't feel
5 that was needed because I thought the key issues were as
6 I've set out.

7 I do accept, though --

8 **Q.** The key issues about whether he could be interviewed and
9 detained are obviously important. The essential issue,
10 relevant for the criminal justice system, was whether --
11 his state of mind at the time. You appreciated that,
12 presumably, having been into a prison before in similar
13 circumstances and assessing someone's state of mind?

14 **A.** I do accept that that's an important facet in terms of
15 his, you know, partial defences available to him. But
16 I guess what I'm suggesting is that if that is something
17 that we think is critical at such an early stage, that
18 I would support and I would suggest that there is more
19 national guidance about that.

20 **Q.** Critical from whose perspective?

21 **A.** Well, critical from the incident management, from those
22 involved, including me and including the patient,
23 including victims.

24 **Q.** Well, that's a lot of inclusions there, isn't there?

25 There's the patient themselves, who may be choosing, in

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1 that I'd need to be clear about exactly how I was --

2 what the function of that was, how it would be
3 documented, and the consideration of the issues to raise
4 with the patient when doing so.

5 **Q.** Well, we know he wasn't taking any treatment or
6 medication. In a patient with a history with mental
7 health services, could you examine someone with a view
8 to treatment and what they needed --

9 **A.** And if, if --

10 **Q.** -- in those circumstances?

11 **A.** Yes -- well, you could if it had been highlighted to you
12 that there were immediate mental health concerns where
13 the patient required immediate treatment.

14 **Q.** So 15 years ago when you were invited to do it, what was
15 the basis then?

16 **A.** The basis then was a patient who was very disturbed in
17 custody, had no prior history of contact -- or had no
18 prior history of having behaved in such a manner. And
19 part of the question was about the extent to which it
20 was reasonable, therefore, to proceed with, you know,
21 the consideration of the criminal justice process with
22 that patient.

23 **Q.** So would your concern have been, in this situation, that
24 without clearer guidance, your obligations to the
25 patient may conflict with findings you may make that

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1 work adversely against that patient in the criminal
2 justice process in very serious cases?
3 **A.** They may do, Ma'am. I don't want to overplay that point
4 but I'm just suggesting that it's, you know, these can
5 be quite complex themes, and that's the evidence that
6 I'd give.
7 **Q.** So you'd need clarity about why you were doing it?
8 **A.** *(The witness nodded).*
9 **Q.** And if you thought it was going to work against the
10 person --
11 **A.** Yes.
12 **Q.** -- you were assessing's interest, you'd be uncomfortable
13 about doing it that without clarity as to whether you
14 could or should?
15 **A.** Well, I would, yes -- well, I'd want to know
16 professionally what that environment was. Yes, I would.
17 **Q.** And when you refer to risks as being involved in the
18 emails, we don't need to go back to them, but were you
19 troubled by that? Troubled by being in that position
20 and potentially having to do that?
21 **A.** I was -- you mean in terms of me stepping forward --
22 **Q.** Yes.
23 **A.** -- to highlight --
24 **Q.** -- and to go and examine the patient in any context,
25 patient as you saw it?

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1 directly from the community, but it would be very
2 unusual for a patient's first referral [to be] to
3 a secure forensic unit ..."
4 So the bottom line in the case of VC is that he
5 would never have met the criteria for referral to
6 a forensic secure institution, would he, before these
7 offences?
8 **A.** I'm mindful to be careful about referring to VC *per se*,
9 having not assessed him previously and only being aware
10 of his case through records and through the Inquiry
11 documents, and other sources. But what I would say is
12 that in secure services, there's always -- part of the
13 referral criteria can be an escalating pattern of risk
14 behaviour towards others. It can be several different
15 types of risk behaviours that it may relate to, and this
16 is potentially about putting together that picture of
17 what that risk profile looks like, gathering
18 information, and making appropriate referral onwards to
19 forensic services.
20 So it is possible for patients to be admitted
21 without, you know, significant conviction history,
22 though I do appreciate that historically in forensic
23 services, you know, patients have tended to be admitted
24 more prevalently because of convictions.

Clearly the picture is different, for example, in

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1 **A.** No, I wasn't troubled to do that. You know, I put
2 myself forward on the day as --
3 **Q.** Who to? Who did you put yourself forward to, as it
4 were?
5 **A.** Well, to the team, to the Liaison and Diversion team, to
6 provide that senior leadership support for them. And
7 I appreciate there may be different critiques of that,
8 and --
9 **Q.** Did you have a direct conversation with Louise Hagan or
10 anyone else in the team about whether they thought it
11 was necessary or not? In other words, aside from the
12 emails, a proper discussion about what they had found,
13 weren't they weren't able to find, and whether it would
14 be useful to have you or another forensic psychiatrist
15 come in?
16 **A.** I don't recall having any detailed discussion about
17 that, no, because as far as I was concerned, we were
18 thinking about the process. This was all a process
19 question, in terms of how the patient would move through
20 the criminal justice system.
21 **Q.** Thank you. If I could move, please, to referrals to
22 secure forensic units and the community forensic
23 generally, you set out in your statement at
24 paragraph 34:

"Some low secure services may admit patients

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1 a low secure service versus medium or high and that's
2 partly because in order to have reached the bar to be
3 admitted to, say, a high secure hospital, the likelihood
4 is that the level of that risk behaviour has been so
5 high that they are likely to have been prosecuted and be
6 in prison, and so on.

7 But there are always cases who escalate up otherwise
8 because of that increasing risk behaviour pattern, and
9 I've assessed some of those patients and I've sometimes
10 admitted those patients.

11 **Q.** Can we have, please, on the screen page 20 of your
12 witness statement so WITN0388001, page 20, and you set
13 out there at paragraph 65 as you've just said:

14 "Patients will sometimes be accepted to the
15 [Community Forensic services Teams] without criminal
16 charges ..."

17 That's right, isn't it.

18 **A.** Yes, that's right. And the Community Forensic Service
19 is, you know, quite a different model. So we're talking
20 about a tiered model here of interventions that can be
21 provided at the various different levels.

22 **Q.** And if we have paragraph 67, which is page 21 on the
23 screen, you see the different levels of intervention and
24 the support that can be offered.

25 **A.** Yes, that's right, Ma'am.

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1 Q. And the criteria is relevant, isn't it, there needs to
 2 be an identifiable mental disorder, but in terms of
 3 people treating VC your evidence is there is an option
 4 for having advice only, joint working and full case
 5 management from forensics where secure detention isn't
 6 required, but the role or involvement of community
 7 services may be.

8 A. So again, I wouldn't wish to refer directly to VC, but
 9 what I would suggest is that colleagues in general adult
 10 services or other non-forensic services, they piece
 11 together the information that they have available to
 12 them, they're assertive about finding that from other
 13 sources, they make a preliminary assessment of what they
 14 think to be that risk assessment and the fact that it's
 15 escalating, and then they approach forensic services to
 16 then consider how they can work with them to manage that
 17 patient more safely.

18 Q. If we can have paragraph 71 -- it's further down the
 19 page, please -- on the screen. It looks as though, in
 20 2024, case consultation, that offer was reworked. So
 21 that's post these events, is it?

22 A. It is Ma'am, yes.

23 Q. Because?

24 A. To ensure that -- as I understand it, to ensure that
 25 that interface with general services was enhanced, you

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1 psychological interventions with patients dealing with
 2 psychosis?

3 A. Well, the usefulness is that they help the patient with
 4 the understanding of their condition. So, you know,
 5 providing medication is obviously important and very
 6 critical in psychosis, as we've heard from other experts
 7 in the Inquiry. But it's also important to equip the
 8 patient with the necessary skills to be able to manage
 9 their condition better, to understand their condition,
 10 how it could be related to risks, how it could affect
 11 their prognosis in the future. You know, so areas such
 12 as substance use, remaining in touch with services and
 13 keeping -- continuing to work with services, informing
 14 us if they are having any relapse symptoms. You know,
 15 all of those areas are very important in terms of their
 16 future prognosis and safety.

17 Q. Paragraph 110, please, page 35. You were asked "what
 18 potential treatment or advice could be provided by
 19 forensic psychiatry where an EIP patient is assessed as
 20 posing a risk to others".

You say:

"... the process by which forensic services may
 become involved in a patient's care and/or provide
 advice is not limited to circumstances in which their
 referral is 'accepted'."

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1 know, partly --

2 Q. Because people weren't using it?

3 A. Because -- well, there could be a range of different
 4 reasons. I mean the -- so some of this is about the
 5 fact that there will, within general services, most
 6 patients won't present with a significant risk towards
 7 other people, but there will be a cohort, a subset, who
 8 will. And this is about highlighting who those people
 9 are at an early stage and being able to intervene early.

10 And so the case consultation was to try to pick
 11 those things up, to signpost, and to support where
 12 possible, and I haven't -- you know, the numbers picked
 13 up significantly, not just in adult mental health
 14 services but also in probation as well.

15 Q. Can we have paragraph 89, page 29, please. You make
 16 reference to psychological interventions here.

17 A. Mm-hm.

18 Q. What are the value of psychological interventions,
 19 particularly in early intervention?

20 A. So psychological interventions could be about
 21 psychoeducation, they could be about understanding the
 22 nature of the patient's mental disorder. I'm just
 23 thinking about the context of this question, sorry,
 24 Ma'am. Do you mind if I just --

25 Q. What's the usefulness of them? What the usefulness of

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1 Shall we have a look at the referral and acceptance
 2 policy at WITN0388006, page 5. This is a 2025 policy,
 3 so subsequent to these events. But it sets out referral
 4 conditions there. And we see at number 2:

"... significant probability of serious harm in that
 the individual's behaviour has or could lead to life
 threatening injury or irreversible harm to others.
 Patients under our service typically have a history of
 GBH, fire setting, stalking ..."

What's the significance of stalking as an offence?

A. Well, it's an offence of psychological harm, which can
 be, you know, significant in nature, and can be
 associated with risk of violence to that person as well
 as the traumatic impact of the stalking behaviour
per se.

Q. This sets out, if we scroll down at 1.4:

"Patients will sometimes, be accepted without
 criminal charges", as you've said.

If we go over the page at page 5, "Pre-referral":

"A system for pre-referral ..."

Sorry, page 6 of the INQ number. In the bottom
 paragraph.

"Professionals considering referral ... from the
 Community Forensic Team is invited to telephone the team
 at bases to discuss cases."

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1 Was that something you're aware of was common or
2 used at all before these events?
3 **A.** It is used. I mean I don't currently work on a regular
4 basis on the Community Forensic Service, but as I noted,
5 I did speak with the operational manager and a forensic
6 psychiatrist does work in that service in order to help
7 inform me more.

8 We do get contacted by clinicians with
9 pre-discussion, pre-referral, with a view to signposting
10 or for full referral. It really -- to an extent, this
11 refers to the earlier question you asked. You know, we
12 seek to have champions in each area who understand this
13 picture and this profile, this risk profile, such that
14 colleagues from general services and from forensic
15 services are able to liaise and we can upscale and
16 support them to work with this challenging group of
17 patients, so that we export some of our expertise and
18 knowledge to them, and work with those patients too,
19 sometimes transfer them to our service.

20 **Q.** Can we have the next page of the document seven,
21 number 7, paragraph 2.6, four levels of response to
22 a referral. We see level 1 "Specialist consultation",
23 level 2 "Forensic assessment", 3 "Collaborative working
24 with referrer", and 4 "Full forensic case management".

25 And if we go over to page 8, please, at 5.2:

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1 **A.** No.

2 **Q.** It should, shouldn't it?

3 **A.** I was quite surprised when I was actually reading this
4 in preparation and I was surprised that it didn't
5 actually make reference to this. I mean, this is not my
6 document, obviously --

7 **Q.** No, I know.

8 **A.** -- it's from the Royal College of Psychiatrists. But,
9 yes, I understand your concern that it doesn't refer to
10 that.

11 **Q.** And it's a serious omission because this is something
12 that's directing psychiatrists to the appropriate
13 standards and the risk to others isn't contemplated
14 within it?

15 **A.** Well, it doesn't make reference to it there in 29,
16 you're right. I can't recall whether there's other
17 references elsewhere. It tends to set out what the key
18 elements of the hospital will look like but I'm not sure
19 there's another risk statement other than that one,
20 Ma'am.

21 **Q.** No, and on discharge and transfer, that's obviously key,
22 isn't it, the risk to others.

23 **A.** Yes, it is, Ma'am, yes.

24 **MS LANGDALE:** Yes, those are my questions.

25 **THE CHAIR:** Any questions?

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1 "Relevant to discharge. Patients accepted on to the
2 caseload as forensic patients will remain in the service
3 until their risk factors have been identified,
4 addressed, treated and reduced to levels which are
5 considered to be acceptable, reasonable and safely
6 manageable out of the service."

7 **A.** Yes. So this is referring, as I understand it, to those
8 patients who are under a level 4, so patients who are
9 case managed by us under CPA. Quite often they're
10 subject to 37/41 or similar orders and they are patients
11 generally who have come through secure services and are
12 now being managed in the community. Some of those are
13 transitional patients and some of them may well require
14 long-term community forensic case management.

15 **Q.** That can come down, please, and can we have WITN0388009.
16 This, Dr Taylor, is the Royal College of Psychiatrists
17 Standards for Forensic Mental Health Services. And if
18 we can go, please, to page 12 the document sets out
19 standards for the service, and we see at page 12, in the
20 bottom box:

21 "Requirement. Mental health practitioners carry out
22 a thorough assessment of the person's personal, social,
23 safety and practical needs to reduce the risk of suicide
24 on discharge".

25 That doesn't mention risk to others on discharge.

90

1 No, thank you.

2 Questioned by THE CHAIR

3 **THE CHAIR:** Just a couple of questions, Dr Taylor. You
4 obviously were working with the forensic psychiatry in
5 Nottingham?

6 **A.** Yes.

7 **THE CHAIR:** We've heard a lot of evidence about adult
8 psychiatry, the general psychiatry, and we also are
9 aware that certainly at Nottingham University Hospital
10 there's a research element into that, with I think it's
11 Dr Whiting, isn't it, who's worked with
12 Professor Fazel --

13 **A.** Yes.

14 **THE CHAIR:** -- on the link between schizophrenia and
15 violence.

16 **A.** Yes, Ma'am.

17 **THE CHAIR:** To what extent do those three parts of the
18 Nottingham healthcare work together?

19 **A.** So, I mean, Dr Whiting is a forensic academic.

20 **THE CHAIR:** Yes.

21 **A.** And so part of his role is clinical and the other part
22 is in terms of medical academia, and the areas, as
23 I understand it, the areas that he would then focus upon
24 would be set out through the Institute of Mental Health,
25 which is hosted through the Trust. I mean --

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1 **THE CHAIR:** What I'm really asking is whether the three
2 different areas inform each other in any way and work
3 together.
4 **A.** They certainly can do. I'm aware, for example, because
5 I know him personally, and I work alongside him in the
6 same care unit, I know that he has a lot of knowledge
7 about the OxMIV tools and other similar ones having
8 worked with Professor Fazel previously, and I'm
9 interested in those in the same way as he is, as
10 potential tools that could be used in the future with
11 a view to trying to guide the appropriateness of
12 referrals into forensic services and looking at what
13 referral criteria could be and how we work together with
14 patients better.

15 So I think that's an area that could do with more
16 work and more research, Ma'am.

17 **THE CHAIR:** And in terms of forensic psychiatry and general
18 adult psychiatry, which we are dealing with largely in
19 this inquiry, you've said in your statement that since
20 this incident there's been a strengthening of, if you
21 like, the interface between general psychiatry and
22 forensic psychiatry. But in terms of risk assessment,
23 would it be helpful for there to be access, and easy
24 access to, in general adult psychiatry -- not for every
25 case, but in the cases where there is a perceived

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1 a period of time, and in general services there are so
2 many external variables, potentially, that it may be
3 complex to do that.

4 **THE CHAIR:** We've been looking through the RiO notes in this
5 Inquiry in some detail and I just wondered whether
6 a forensic psychiatrist would look through those notes
7 and pick out things in a rather different way, with your
8 experience of dealing with a particular cohort of
9 patients?

10 **A.** And that's something, Ma'am, we do do in terms of the
11 joint interventions part of the community forensic
12 model, for example. And so in other words we work with
13 general services to put together an HCR-20 with them and
14 can support them to do that. But again, it very much
15 then depends, well having done that bit of work and
16 stepped away, where does that then go for the patient's
17 future journey?

18 And that, as I say, my experience of HCR-20 is very
19 much about a structured inpatient pathway with exposure
20 to different levels of -- graded exposure to the
21 community during that pathway.

22 **THE CHAIR:** I wasn't thinking so much of just a simple risk
23 assessment and then go, as it were --

24 **A.** Yes.

25 **THE CHAIR:** -- but really more about being more involved in

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1 problem, a number of different incidents of violence,
2 whether serious violence or a cumulative pattern -- to
3 have access to a forensic psychiatry risk assessment?

4 **A.** Yes, this is an area I've thought a bit about and,
5 whilst I'm not an expert *per se* in terms of HCR-20, I
6 understand it, I do know about risk to others, to an
7 extent, and therefore, you know, as I say, I've
8 reflected upon it. And for me the key issue is how you
9 pick out and stratify that high-risk group of patients
10 and you need something to be able to pick them up, you
11 know, a tool, whether it's OxMIV or something else,
12 something to be able to pick up who those individuals
13 are, and then you could potentially consider something
14 such as the HCR-20.

15 That said, my experience of using HCR-20 is that
16 it's highly structured and it's -- it's aligned with
17 very structured pathways. And so if this is not
18 underpinning all aspects of that patient's care
19 otherwise, then I guess I would be concerned that that's
20 perhaps not something that's as embedded in the
21 day-to-day practice as it needs to be. So in other
22 words I guess what I'm saying is it's not
23 a transactional thing this, you don't just do the risk
24 assessment as a one-off and it's done; it has to be
25 there on an ongoing basis, adjusted, considered over

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1 the development of -- particularly those patients who
2 come back on a number of occasions.

3 **A.** I totally agree, Ma'am. I mean I think one of the areas
4 that would -- that I think would be really critical in
5 terms of the future development of services is for us to
6 be more involved in those cases, working alongside
7 Assertive Outreach models as well, which there has been
8 some renewed interest in in recent times, but community
9 forensic is also a really important area, and for
10 inpatient forensic psychiatrists to be involved in that
11 process too.

12 There are Community Forensic National Standards
13 being redeveloped again but they're not necessarily
14 connected in with commissioning on a local basis, and
15 that's problematic because it leads to national
16 differences across different areas based on local
17 funding, and for me, this one of the really critical
18 bits of the future development of forensic services.

19 **THE CHAIR:** Yes, and just the point that Ms Langdale asked
20 you about, that's the Royal College of Psychiatrists,
21 the omission in the Standards for Forensic Mental Health
22 Services, do you think the omission of risk to others is
23 because there has been more emphasis recently on risk to
24 self?

25 **A.** Yes, I think that's probably the case. But I can't

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1 really talk to why it isn't -- it isn't there, Ma'am.
 2 **THE CHAIR:** No.
 3 **A.** It's odd, and I have to say, and, like I said earlier in
 4 my evidence, it was surprising to me that it didn't
 5 specifically refer to that risk.
 6 **THE CHAIR:** Thank you.
 7 Right, we'll start again -- thank you -- Monday.
 8 **(4.20 pm)**
 9 **(The hearing adjourned until 10.00 am on Monday 11 May 2026)**
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